CITY OF CROWN POINT

EMPLOYEE HEALTH PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

(February, 2005)

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ADOPTION

The City of Crown Point has caused this restated City of Crown Point Employee Health Plan ***(Plan)*** to take effect as of the first day of February, 2005, at Crown Point, Indiana. This is a revision of the Plan previously adopted January 1, 2001. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by the City of Crown Point.

BY: Daniel M Klein DATE: 5-23-05

SUMMARY PLAN DESCRIPTION

Name of Plan:

City of Crown Point Employee Health Plan

Name, Address and Phone Number of Employer/Plan Sponsor:

City of Crown Point
101 North East Street
Crown Point, Indiana 46307
Phone: (219) 661-2284

Type of Plan:

Welfare Benefit Plan: medical, dental and prescription drug benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through a company contracted by the ***employer*** and shall hereinafter be referred to as the ***claims processor.***

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:

City of Crown Point
101 North East Street
Crown Point, Indiana 46307
Phone: (219) 662-3235

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following sections:

Eligibility
Enrollment
Effective Date of Coverage

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, ***pre-existing conditions,*** or ***termination of coverage,*** refer to the following sections:

Schedule of Benefits
Effective Date of Coverage, Pre-existing Conditions
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from the ***covered employees*** and their covered ***dependents.*** The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the ***covered employees.***

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***covered persons*** are used to cover ***Plan*** costs and are expended immediately.

Ending Date of Plan Year:

December 31st

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedures.*

The designated ***claims processor*** is:

Stewart C. Miller & Co., Inc.
3440 Kossuth Street
PO Box 5769
Lafayette, Indiana 47903-5769
Phone: (765) 447-8803
(800) 552-6550

HIPAA PRIVACY STATEMENT

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The ***Plan*** will use protected health information (PHI) to the extent of an in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the ***Plan*** will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the ***Plan*** to obtain premiums or determine or fulfill its responsibility for coverage and provision of ***Plan*** benefits that relate to a ***covered person*** to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and coinsurance amounts (for example, cost of a benefit or ***Plan*** maximums as determined for a ***covered person's*** claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing ***employee*** contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
- Reimbursement to the ***Plan.***

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and ***Plan*** performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the ***Plan,*** including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the ***Plan***, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or

(b) customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;

- Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BYAUTHORIZATION OF THE COVERED PERSON

With an authorization, the ***Plan*** will disclose PHI to other health benefit plans, health insurance issuers or HMOs for purposes related to the administration of these plans.

The ***Plan*** will disclose PHI to the ***Plan administrator*** only upon receipt of a certification from the ***Plan administrator*** that the ***Plan*** documents have been amended to incorporate the following provisions.

WITH RESPECT TO PHI, THE PLAN ADMINISTRATOR AGREES TO CERTAIN CONDITIONS

The ***Plan administrator*** agrees to:

- Not use or further disclose PHI other than as permitted or required by the ***Plan*** document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the ***Plan administrator*** provides PHI received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***Plan administrator*** with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by a ***covered person;***
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the ***Plan administrator*** unless authorized by the ***covered person;***
- Report to the *Plan* any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a ***covered person*** in accordance with HIPAA's access requirements***;***
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the ***Plan*** available to the Health and Human Services Secretary for the purpose of determining the ***Plan's*** compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the ***Plan*** that the ***Plan administrator*** still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Effective April 20, 2005:

- **Reasonable and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the *Plan administrator* on behalf of the *Plan.* Specifically, such safeguarding entails an obligation to:**
  - **Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the *Plan administrator* creates, receives, maintains or transmits on behalf of the *Plan;***
  - **Ensure that the adequate separation as required by 45 C.F.R. 164-504(f)(20(iii) is supported by reasonable and appropriate security measures;**

- **Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and**
- **Report to the *Plan* any security incident of which it becomes aware.**

SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

The following ***employees*** or classes of ***employees*** under the control of the ***Plan administrator*** may be given access to PHI by the ***Plan*** or a business associate servicing the ***Plan:***

1. Human Resources Director

2. Mayor's Office

3. Clerk Treasurer's Office

The ***employees*** who are included in this description will have access to PHI only to perform the administration functions that the ***Plan administrator*** provides to the ***Plan***. ***Employees*** who violate this provision will be subject to sanction. The ***Plan administrator*** will promptly report any violation of this provision to the ***Plan*** and will cooperate with the ***Plan*** to remedy or mitigate the effect of such violation.

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Utilization Review, Medical Expense Benefit, Prescription Drug Program, Dental Expense Benefit, Plan Exclusions* and *Preferred Provider Organization.*

MEDICAL BENEFITS:

Maximum Benefit Per Covered Person While Covered By This Plan For:

Medical	$1,000,000
Transplant	$250,000

Maximum Benefit Per Covered Person Per Calendar Year For:

Extended Care Facility	60 days
Inpatient Mental and Nervous Disorders	30 days
Outpatient/Partial Confinement Mental and Nervous Disorders	25 visits
Inpatient Chemical Dependency	$7,000
Outpatient Chemical Dependency	$2,000
Private Duty Nursing	$20,000
Outpatient Physical, Occupational, Respiratory and Speech Therapy	$5,000
Temporomandibular Joint Dysfunction	$1,000
Preventive Care	1 routine exam
Chiropractic Care	$1,000

Calendar Year Deductible:

	Preferred Provider	***Nonpreferred Provider***
Individual (Per Person)	$100	$200
Family (Aggregate)	$300	$600

Copays Per Admission Or Occurrence: (Refer to *Medical Expense Benefit, Copay)*

Preferred Provider Home and Office Visits	$10
Preferred Provider Emergency Room Visit	$50

Out-of-Pocket Expense Limit Per Calendar Year: (excludes deductible)

	Preferred Provider	***Nonpreferred Provider***
Individual (Per Person)	$500	$1,000
Family (Aggregate)	$1,500	$3,000

Refer to *Medical Expense Benefit, Calendar Year Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit. Amounts applied toward satisfaction of the ***preferred provider*** out-of-pocket expense limit may also be applied toward satisfaction of the ***nonpreferred provider*** out-of-pocket expense limit and vice versa.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical*

Expense Benefit, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

Benefit Description	***Preferred Provider***	***Nonpreferred Provider***
Inpatient Hospital	90%	70%
Outpatient Surgery	90%	70%
Emergency Room Services (Deductible waived for ***preferred providers***) (***Copay*** waived if admitted)	100% after $50 ***copay***	70%
Accident Expense Benefit (Deductible waived for ***preferred provider***) Limitation: $300 ***maximum benefit*** per accident	100%	70%
Physician's Services		
Home and Office Visit (Deductible waived for ***preferred providers***) (One ***copay*** applies to all services performed during office or home visit)	100% after $10 ***copay***	70%
Inpatient Visit	90%	70%
Surgery - Physician's Office	90%	70%
Surgery - Other	90%	70%
Pathology	90%	70%
Anesthesiology	90%	70%
Radiology	90%	70%
Second Surgical Opinion (Deductible waived)	100%	100%
Diagnostic X-rays & Lab		
Inpatient or Outpatient	90%	70%
Extended Care Facility Limitation: 60 days ***maximum benefit*** per calendar year	90%	70%
Home Health Care	90%	70%
Hospice Care	90%	70%
Durable Medical Equipment	90%	70%
Preventive Care Limitation: 1 routine exam per calendar year	100% after $10 ***copay***	Not Covered
Mental & Nervous Disorders		
Inpatient Services Limitation: 30 days ***maximum benefit*** per calendar year	70%	50%
Outpatient/Partial Confinement Services Limitation: 25 visits ***maximum benefit*** per calendar year	70%	50%

Benefit Description	***Preferred Provider***	***Nonpreferred Provider***
Chemical Dependency		
Inpatient Services Limitation: $7,000 ***maximum benefit*** per calendar year	70%	50%
Outpatient Services Limitation: $2,000 ***maximum benefit*** per calendar year	70%	50%
Therapy Services Limitation: $5,000 ***maximum benefit*** per calendar year for outpatient physical, occupational, respiratory and speech therapy	90%	70%
Private Duty Nursing Limitation: $20,000 ***maximum benefit*** per calendar year	90%	70%
Transplants Limitation: $250,000 ***maximum benefit*** while covered by this ***Plan*** $10,000 ***maximum benefit*** per transplant for acquisition of organ	90%	70%
Temporomandibular Joint Dysfunction Limitation: $1,000 ***maximum benefit*** per calendar year	90%	70%
Chiropractic Care Limitation: $1,000 ***maximum benefit*** per calendar year	100% after $10 ***copay***	Not Covered
All Other Covered Expenses	90%	70%

PRESCRIPTION DRUG PROGRAM:

Maximum Benefit Per Person Per Calendar Year: (Pharmacy and Mail Order Option Combined)	$20,000
Participating Pharmacy	
Prescription Drug Card Copay	100% after copay; Generic: $10 ***copay*** Brand Name: $20 ***copay***
Nonparticipating Pharmacy	Copay, plus the difference in cost between the ***participating pharmacy*** and ***nonparticipating pharmacy***.

Limitation: 30 day supply and one refill

If no ***generic*** equivalent drug is available for a prescription, the ***covered person*** will be responsible only for the ***copay*** applicable to a ***generic drug.*** Maintenance drugs must be purchased through the *Mail Order Option.*

Mail Order

Mail Order Prescriptions Copay	100% after copay; Generic: $20 per prescription Brand Name: $40 per prescription

Limitation: 90 day supply

If no ***generic*** equivalent drug is available for a prescription, the ***covered person*** will be responsible only for the ***copay*** applicable to a ***generic drug.***

DENTAL BENEFITS

Calendar Year Deductible:

Individual	$50
Family (3 Individuals)	$150

The deductible is waived for Class I - Preventive Dental Services.

Maximum Benefit Per Covered Person:

Class I - Preventive, Class II - Basic and Class III - Major services per calendar year (other than Orthodontics)	$1,000
Orthodontic services while covered by this ***Plan***	$1,000

Percentage of Customary and Reasonable Amount Payable For:

Class I - Preventive Dental Services	100%
Class II - Basic Dental Services	80%
Class III - Major Dental Services	50%
Class IV - Orthodontic Services (***dependent*** children under age 19 only)	50%

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care. ***Utilization review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.***

Certification of ***medical necessity*** and appropriateness by the ***Utilization Review Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

The ***Plan*** requires precertification of certain services, supplies or treatment, as specified below. Under this ***Plan's*** claim filing procedures, the precertification call is considered to be filing a ***pre-service claim*** for benefits. Please see *Claim Filing Procedures* for details regarding a ***covered person's*** rights regarding ***pre-service claim*** determinations and appeals.

PRECERTIFICATION

Hospital/Surgery

All ***hospital*** admissions and ***inpatient*** or ***outpatient*** surgeries are to be certified in advance of the proposed ***confinement*** or surgery (precertification) by the ***Utilization Review Organization,*** except for ***emergencies***. The ***covered person*** or their representative should call the ***Utilization Review Organization*** at least forty-eight (48) hours prior to admission or surgery.

Covered persons should contact the Utilization Review Organization by calling the number shown on their identification card.

Emergency hospital admissions are to be reported to the ***Utilization Review Organization*** within forty-eight (48) hours following admission.

*Group health plans generally may not, under federal law, restrict benefits for any **hospital** length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the **Plan** for prescribing a length of stay not in excess of the above periods.*

***Covered expenses* for *hospital confinement* and *inpatient* or *outpatient* surgeries shall be reduced by fifty percent (50%) to a maximum of two hundred dollars ($200) for the purpose of determining benefits payable if precertification is not obtained.**

After admission to the ***hospital***, the ***Utilization Review Organization*** will continue to evaluate the ***covered person's*** progress through ***concurrent review*** to monitor the length of ***confinement*** and ***medical necessity*** of treatment. If the ***Utilization Review Organization*** disagrees with the length of ***confinement*** recommended by the ***physician,*** the ***covered person*** and the ***physician*** will be advised. If the ***Utilization Review Organization*** determines that continued ***confinement*** is no longer necessary, additional days will not be certified. **Benefits payable for days not certified as *medically necessary* by the *Utilization Review Organization* shall be denied.**

However, in the event that a ***retrospective review***, (a review completed after the event), determines that the hospitalization or surgery did not exceed the amount that would have been approved had the precertification been

completed, there will be no penalty assessed and the amount of any deductible and/or ***coinsurance*** will count towards the satisfaction of the ***covered person's*** maximum out-of-pocket expense.

Precertification from the ***Utilization Review Organization*** does not constitute ***Plan*** liability for any ***pre-existing condition*** charges during the ***pre-existing condition*** waiting period.

Extended Care Facility/Hospice/Home Health Care/Outpatient Durable Medical Equipment in excess of $100/Outpatient Medical Supplies in excess of $200/Outpatient IV Chemotherapy/Outpatient Infusion Therapy/Outpatient Mental & Nervous or Chemical Dependency Treatment after the 4th visit/Outpatient Occupational, Speech, Orthopedic and Physical Therapy/Outpatient Diagnosis and Treatment of Sleep Apnea

Precertification by the ***Utilization Review Organization*** is required for ***extended care facility confinements, hospice care, home health care, outpatient*** purchase or rental of ***durable medical equipment*** in excess of one hundred dollars ($100), ***outpatient*** medical supplies in excess of two hundred dollars ($200) per supply, ***outpatient*** intravenous chemotherapy, ***outpatient*** infusion therapy, ***outpatient*** treatment of ***mental and nervous disorders*** or ***chemical dependency*** after the fourth visit, ***outpatient*** physical, occupational, speech or orthopedic therapy and ***outpatient*** diagnosis and treatment of sleep apnea***.*** The ***covered person*** or their representative should call the ***Utilization Review Organization*** prior to the ***confinement*** or service.

PRECERTIFICATION APPEAL PROCESS

In the event certification of ***medical necessity*** is denied by the ***Utilization Review Organization,*** the ***covered person*** may appeal the decision. See *Claim Filing Procedures* for more information concerning the appeal process.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***employer*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***employer*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost effective result without a sacrifice to the quality of care. The use of case management or alternate treatment is a voluntary program to the ***covered person,*** however, the ***Plan*** will generally provide a greater benefit to the ***covered person*** by participating in the program.

Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider.***

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***nonpreferred provider. Covered persons*** should contact the Human Resources Department for a current listing of ***preferred providers.***

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization.*** This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense.*** The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person.***

REFERRALS

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to assure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. ***Medically necessary*** services, supplies and treatments not available through any ***preferred provider.***

2. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a ***nonpreferred provider*** when the ***facility*** rendering such services is a ***preferred provider.***

3. While confined to a ***preferred provider hospital,*** the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider.***

4. ***Nonpreferred*** anesthesiologist if the operating surgeon is a ***preferred provider.***

5. ***Emergency*** treatment rendered at a ***nonpreferred facility.*** If the ***covered person*** is admitted to the ***hospital*** after such ***emergency*** treatment, ***covered expenses*** shall be payable at the ***preferred provider*** level.

6. When a covered ***dependent*** resides outside the service area of the ***Preferred Provider Organization,*** for example a ***full-time student, covered expenses*** shall be payable at the ***preferred provider*** level of benefits.

7. ***Covered persons*** who do not have access to ***preferred providers*** within fifty (50) miles of their place of residence, or for ***emergency*** treatment rendered while traveling out-of-area.

8. Diagnostic laboratory and pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider.***

GATEWAY MEDICAL RESOURCE ALLIANCE

GATEWAY HEART PROGRAM

The ***Plan*** includes the following benefits for cardiovascular care. If this section conflicts with any other part of the ***Plan,*** this section will prevail. This benefit supercedes any prior cardiovascular benefit.

Covered Heart Procedures

Any of the following ***medically necessary*** cardiovascular procedures:

- Heart catheterization, ***inpatient*** and ***outpatient***
- Angioplasty, ***inpatient*** and ***outpatient***
- Coronary artery stenting, ***inpatient*** and ***outpatient***
- Coronary artery by-pass graft (CABG)
- Coronary intravascular Brachytherapy (not available at all sites)
- Drug eluting stenting (when FDA approved)
- Valve repair and/or replacement
- Cardiac defibrillator and pacemaker implants (not available at all sites)
- Electrophysiology procedures (not available at all sites)
- Other major cardiovascular procedures and treatment of heart attacks
- Any combination of the above

Professional Component

A. Cardiothoracic/vascular surgeons(s), assistant surgeon(s) and assistants
B. Cardiologist(s), invasive and noninvasive
C. Anesthesiologist(s), and assistants
D. Radiologist(s), excluding invasive procedures
E. Pathologist(s), to include the following specific procedures:
    - Surgical pathology
    - Interpretation of lab test
F. Admitting history and physical examination and/or comprehensive consultation
G. Readmission
    - Additional or repeat surgical procedure, if performed on the same vessel by the cardiologist/cardiothoracic/vascular surgeon within thirty (30) days of the original cardiac surgery
    - Readmissions under the care of the cardiologist or cardiovascular surgeon within thirty (30) days of the original cardiac surgery if such readmission is related to the original cardiac surgery
    - The intent of this provision is to offer added value to the ***Plan*** and the patient, and is not, and shall not be construed as an admission of negligence on the part of a Gateway provider
H. Consultations as needed for evaluation and treatment of complications arising from the original procedure
I. Preadmission testing

Facility Component

A. ***Inpatient hospital*** pre-admission testing within seventy-two (72) hours of admission

B. ***Semi-private room and board,*** including ***intensive care units*** or other specialty room, for as long as needed until the patient can be discharged from the acute-care ***hospital***
C. Operating room services
D. Medical and surgical supplies and devices
E. Medications
F. Laboratory tests
G. X-rays
H. All other routine tests
I. Charges resulting from readmission to the ***hospital*** for a complication which occurs as a result of the original cardiac surgery, if readmission occurs within thirty (30) days of the original cardiac surgery
J. ***Outpatient*** cath lab services

Exclusions

A. Experimental/investigational drugs or medical devices. If medical care (i.e. medical devices, procedure, treatment, or drug therapy) which is experimental/investigational in nature is rendered, any costs above and beyond the normal standard cost of care and/or complications arising from this medical care will be paid by the institution or sponsor of the clinical trial

- Experimental is defined as the absolute risk of the treatment and the safety and effectiveness has not yet been established
- Investigational is defined as the medical use of a non-FDA (Food and Drug Administration) approved drug or medical device not yet recognized in the United States as safe and effective or there is incremental risk for an already approved investigational drug or medical device for diagnosis or treatment. This includes, but is not limited to, all phases of clinical trials and drugs approved by the FDA under its Treatment Investigational New Drug regulation

B. Non-acute care. Gateway is not responsible for any care, which can be rendered in any ***facility*** other than an acute-care ***hospital*** or ***outpatient*** cath lab
C. Hemophilia. If a patient is or has been diagnosed with hemophilia, he or she will not be eligible to receive care at case rates
D. Unrelated conditions. Treatment for conditions unrelated to the original procedure whether or not such conditions were present or known prior to performance of the original procedure
E. Covered procedures. The global case rate listed above does not include any procedure other than those listed above. Services NOT included within the global care rate pricing include prescription drugs, diagnostic services and office calls/visits
F. Pediatric patients. The case rates do not apply to pediatric procedures.

Preventive and Wellness Education

Heart Disease Risk Management

Heart health questionnaire consisting of seventeen (17) questions regarding family heart history and lifestyle behavior. Results are accumulated into two (2) reports – Group Aggregate Report and Confidential Individual Health Profile Report.

Gateway Affiliated Physicians, Hospital & Healthcare Facilities

If ***covered persons*** choose to receive care from Gateway, only those ***physicians, hospitals*** and healthcare ***facilities*** affiliated with Gateway may be selected if the ***covered person*** wishes to receive the global case rate without cost sharing (deductible and ***coinsurance***). As a result, ***coinsurance*** and deductibles may apply. The ***claims processor*** adjudicates claims and benefits under standard ***Plan*** provisions.

Emergency Care

If the ***covered person*** requires ***emergency*** medical treatment and is taken to the nearest appropriate ***hospital*** for any of the above procedures, or the ***covered person*** is scheduled for surgery for any of the above procedures from a provider other than a Gateway provider as of the ***effective date*** of this provision, the ***Plan's*** standard provisions apply.

GATEWAY CANCER CARE PROGRAM

The ***Plan*** includes the following benefits for cancer care. If this section conflicts with any other part of the ***Plan,*** this section will prevail. This benefit supercedes any prior cancer care benefit.

Covered Cancer Procedures

Any of the following, ***medically necessary*** cancer procedures:

1. ***Outpatient*** Autologous Stem Cell Transplant for
   - Breast Cancer
   - Ovarian Cancer
   - Hodgkin's Lymphoma
   - Non-Hodgkin's Lymphoma
   - Multiple Myeloma
   - Leukemia
2. High Dose Rate Brachytherapy – Prostate Cancer
3. Brachytherapy – Mammosite Radiation Treatment
4. Positron Emission Tomography (P.E.T. Scan) for:
   - Single Pulmonary Nodule
   - Non-Small Cell Lung Cancer
   - Colorectal Cancer
   - Melanoma
   - Head and Neck Cancer
   - Esophageal Cancer
   - Refractory Seizures
   - Lymphoma
   - Breast Cancer
5. Chemotherapy for:
   - Colorectal Cancer
   - Non-Small Cell Lung Cancer
   - Breast Cancer
   - Ovarian Cancer
   - Prostate Cancer
   - Hodgkin's Lymphoma
   - Non-Hodgkin's Lymphoma
6. Blood Transfusion
7. Zevalin Therapy for
   - Non-Hodgkin's Lymphoma
8. External Beam Radiation Therapy for:
   - Rectal Cancer
   - Non-Small Cell Lung Cancer
   - Breast Cancer
   - Prostate Cancer
9. External Beam Radiation Therapy including BAT Therapy for
   - Prostate Cancer

Professional Component, Stem Cell Transplants Performed On an Outpatient Basis

A. Office visits with transplant ***physician***
B. PBSC pheresis monitoring and supervision
C. Unlimited nursing assessments
D. Clinical psychosocial patient/family counseling
E. ***Physician*** monitoring and supervision of chemotherapy administration
F. ***Physician*** interpretation of laboratory tests
G. Case conferences between transplant ***physician*** and primary care ***physician***
H. Weekly multidisciplinary stem cell transplant rounds
I. ***Physician hospital*** visits

Technical Component, Stem Cell Transplants

A. Administration of chemotherapy agents
B. Administration of blood products
C. Pharmacy services
   - Mixing
   - Compounding
   - Other services related to chemotherapy treatment
D. Nursing services
   - Assessments
   - Monitoring and administration of chemotherapy agents
   - monitoring and administration of blood products
   - Administration of cytokine therapy
   - Central line maintenance
E. Patient and caregiver education

Peripheral Blood Stem Cells Collection, Stem Cells Transplant

A. Processing
B. Storage
C. Transportation
D. Reinfusion

Laboratory Charges, Stem Cell Transplants

A. All tests related to transplantation and chemotherapy administration

Drugs and Biologicals, Stem Cell Transplants

A. Chemotherapy agents
B. Cytokines (Procrit, Neupogen, Leukine)
C. Electrolyte and fluid replacement
D. Antimetics
E. Antibiotics
F. Analgesics
G. Nutritional therapy

Professional Component – Brachytherapy

A. Oncologist(s) and assistants
B. Anesthesiologist(s) and assistants
C. General surgeon(s) and assistant

D. Radiologist (s) to include the following procedures:
   - Interpretation of radiological procedures related to Brachytherapy
E. Pathologist(s) to include the following procedures:
   - Surgical pathology
   - Interpretation of lab tests
F. Admitting history and physical examinations
G. Consultations as needed for evaluation and treatment of complications arising from original procedure

Facility Component – Brachytherapy

A. ***Outpatient*** surgical center services
B. ***Semi-private room and board*** when ***medically necessary*** as determined by the oncologist(s)
C. Medical and surgical supplies and devices
D. Medications
E. Laboratory tests
F. X-rays
G. All other routine charges

Technical Component – Brachytherapy

A. Radiological procedures and supplies

Professional Component – P.E.T. Scans

A. Radiologist(s) to include the following procedures:
   - Interpretation of P.E.T. Scans

T*technical Component – P.E.T. Scans

A. Radiological procedures and supplies
B. Technicians and assistants

Professional Component – Chemotherapy

A. Office visit
B. Radiologist interpretation of Chest X-ray (and P.E.T. Scan/CAT Scan if needed)
C. ***Physician*** interpretation of lab tests
D. ***Physician*** monitoring and supervision of chemotherapy administration

Laboratory – Chemotherapy

A. CBC and CMET tests and Venipuncture

Technical Component – Chemotherapy

A. Administration of chemotherapy agents
B. Administration of blood products, if needed
C. Pharmacy services
   - Mixing
   - Compounding
   - Other services related to chemotherapy treatment
D. Nursing services
   - Assessments
   - Monitoring and administration of chemotherapy agents

- Monitoring and administration of blood products
- Central line maintenance

E. Radiology
- CAT Scans (if needed)
- P.E.T. Scan (if needed)
- Chest X-ray

Professional Component – Conformal External Beam Radiation Therapy (with or without BAT)

A. Treatment planning
B. Weekly treatment management
C. Weekly physics
D. Radiologist interpretation of CAT Scans
E. ***Physician*** interpretation of lab tests

Technical Component – Conformal External Beam Radiation Therapy (with or without BAT)

A. Radiation External Beam Procedure
B. Complex Simulation
C. CAT Scan
D. 3D Simulation
E.. Dose calculation
F. Diode/TLD
G. Port films
H. BAT (Ultrasound for prostate only)

Laboratory – Conformal External Beam Radiation Therapy (with or without BAT)

A. CBC and Venipuncture

Professional Component – Blood Transfusions

A. Office visit

Technical Component – Blood Transfusions

A. Nursing services
- Assessment
- Monitoring and administration of blood products

Laboratory – Blood Transfusions

A. Red blood cells or single donor platelets (as ordered)

Professional Component – Zevalin Therapeutic Regimen

A. Consultation
B. Follow-up office visits
C. Radiologists interpretation of PET Scan and Gamma Scan
D. ***Physician*** interpretation of lab tests

Technical Component – Zevalin Therapeutic Regimen

A. Administration of chemotherapy agents
B. Administration of blood products if needed
C. Pharmacy services
   - Mixing
   - Compounding
   - Various drugs (Ativan, Benadryl, Rituxan, Zevalin)
   - Other services related to chemotherapy treatment
D. Nursing services
   - Assessments
   - Monitoring and administration of chemotherapy agents
   - Monitoring and administration of blood products
   - Central line maintenance

Laboratory – Zevalin Therapeutic Regimen

A. CBC, CMET and Venipuncture

Exclusions

A. Experimental/investigational drugs or medical devices. If medical care (i.e. medical devices, procedure, treatment, or drug therapy) which is experimental/investigational in nature is rendered, any costs above and beyond the normal standard cost of care and/or complications arising from this medical care will be paid by the institution or sponsor of the clinical trial

   - Experimental is defined as the absolute risk of the treatment and the safety and effectiveness has not yet been established
   - Investigational is defined as the medical use of a non-FDA (Food and Drug Administration) approved drug or medical device not yet recognized in the United States as safe and effective or there is incremental risk for an already approved investigational drug or medical device for diagnosis or treatment. This includes, but is not limited to, all phases of clinical trials and drugs approved by the FDA under its Treatment Investigational New Drug regulation

B. Hemophilia. If a patient is or has been diagnosed with hemophilia, he or she will not be eligible to receive care at case rates
C. Unrelated conditions. Treatment for conditions unrelated to the original procedure whether or not such conditions were present or known prior to performance of the original procedure
D. Covered procedures. The global case rate listed above does not include any procedure other than those listed above.
E. Reinfusion of stem cells. In the event the patient does not complete reinfusion of stem cells, the global case rate will NOT apply and any procedures ***incurred*** will be billed under the patient's standard ***Plan*** provisions.
F. Pediatric patients. The case rates do not apply to pediatric procedures.

Gateway Affiliated Physicians, Hospital and Healthcare Facilities

If ***covered persons*** choose to receive care through Gateway, only those ***physicians, hospitals*** and healthcare ***facilities*** affiliated with Gateway may be selected if the ***covered person*** wishes to receive the global case rate without ***coinsurance.*** A complete listing of Gateway's affiliated ***physicians, hospitals*** and healthcare ***facilities*** may be accessed online at www.gmra.com.

Unaffiliated Physicians, Hospital and Healthcare Facilities

If any of the above covered procedures (case rates) are received from ***physicians, hospitals*** or healthcare ***facilities*** which are not affiliated with Gateway, standard ***Plan*** benefits apply.

Emergency Care

If the ***covered person*** requires ***emergency*** medical treatment and is taken to the nearest appropriate ***hospital*** for any of the above procedures, or the ***covered person*** is scheduled for surgery for any of the above procedures from a provider other than a Gateway provider as of the ***effective date*** of this provision, the ***Plan's*** standard provisions apply.

GATEWAY ORTHOPAEDIC SERVICES PROGRAM

The ***Plan*** includes the following benefits for orthopaedic care. If this section conflicts with any other part of the ***Plan,*** this section will prevail. This benefit supercedes any prior orthopaedic care benefit.

Covered Orthopaedic Procedures

Any of the following ***medically necessary,*** orthopaedic procedures performed on an ***outpatient*** basis:

- Removal of surgical implants
- Claviculectomy
- Claviculectomy with 1 additional procedure
- Arthroscopy of the shoulder
- Arthroscopy of the shoulder with 1 or 2 additional procedures
- Arthroscopy of the shoulder with Claviculectomy
- Arthroscopy of the shoulder with Claviculectomy with a or 2 additional procedures
- Arthroscopy of the knee
- Arthroscopy of the knee with 1 or 2 additional procedures
- Arthroscopy of the knee with Meniscectomy
- Arthroscopy of the knee with Meniscectomy with 1 or 2 additional procedures
- Arthroscopy of the knee with bone grafting with or without fixation
- Arthroscopy of the knee with bone grafting with or without fixation with 1 or 2 additional procedures
- Anterior Cruciate Ligament (ACL) Repair
- Lumbar Laminectomy with Microscope
- Lumbar Laminectomy with Lumbar Arthrodesis with Instrumentation
- Diskectomy of Anterior Cervical Disk with Arthrodesis
- Release of Carpal Tunnel
- Release of Carpal Tunnel with 1 or 2 additional procedures
- Diskectomy of Anterior Cervical Disk
- Diskectomy of Anterior Cervical Disk with Arthrodesis

Professional Component

A. Orthopaedic surgeon(s), assistant surgeon(s) and assistants
B. Anesthesiologist(s) and assistants
C. Radiologist(s), excluding invasive procedures
D. Pathologist(s), to include the following specific procedures:
   - Surgical pathology
   - Interpretation of lab test
E. Admitting history and physical examination and/or comprehensive consultation
F. Readmission:

- Additional office-based medical care, if performed on the same joint/location by the orthopaedic surgeon, under the care of a Gateway affiliated ***physician*** within a thirty (30) day period following discharge for treatment of complications directly related to the performed procedure.
- The intent of this provision is to offer added value to the ***Plan*** and the patient, and is not and shall not be construed as an admission of negligence on the part of a Gateway provider.

G. Consultations as needed for evaluation and treatment of complications arising from the original procedure.

Facility Component

A. Operating room care and staffing, including pre-operative care, post-operative care and recovery
B. Recovery rooms and medical/surgical supplies, devices, prosthetics, surgical dressings, splints, cases and other devises used during the operation
C. Inter-operative medications
D. Laboratory tests
E. Inter-operative X-rays
F. All other routine charges
G. Pre-admission testing limited to EKG, glucose and ***pregnancy*** testing the day of surgery
H. ***Outpatient*** surgical center
I. ***Durable medical equipment*** used during the procedure
J. Charges for office-based medical care resulting from treatment of a complication which occurs as a result of the original orthopaedic surgery, if care occurs within thirty (30) days of the original surgery.

Exclusions

A. Experimental/investigational drugs or medical devices. If medical care (i.e. medical devices, procedure, treatment, or drug therapy) which is experimental/investigational in nature is rendered, any costs above and beyond the normal standard cost of care and/or complications arising from this medical care will be paid by the institution or sponsor of the clinical trial

    - Experimental is defined as the absolute risk of the treatment and the safety and effectiveness has not yet been established
    - Investigational is defined as the medical use of a non-FDA (Food and Drug Administration) approved drug or medical device not yet recognized in the United States as safe and effective or there is incremental risk for an already approved investigational drug or medical device for diagnosis or treatment. This includes, but is not limited to, all phases of clinical trials and drugs approved by the FDA under its Treatment Investigational New Drug regulation

B. Non-acute care. Gateway is not responsible for any care, which can be rendered in any ***facility*** other than an ***outpatient*** surgical center for orthopaedic care
C. Hemophilia. If a patient is or has been diagnosed with hemophilia, he or she will not be eligible to receive care at case rates
D. Unrelated conditions. Treatment for conditions unrelated to the original procedure will be billed separately, whether or not such conditions were present or known prior to performance of the original procedure
E. Episode of Care. The episode of care covered by the global case rate begins with admission to surgical center for a contracted procedure and ends upon discharge from the ***facility.*** The case rate does not include any procedure other than those listed above. Services not included within the case rate include ***outpatient*** prescription drugs, diagnostic services performed prior to admission (other than pre-admission testing) and following discharge. Follow-up office visits will be included or excluded from the case rate consistent within the guidelines contained in the current volume of Current Procedural Terminology.
F. Work-Related Injuries. Treatment for ***injuries*** and conditions ***incurred*** while at the patient's place of employment or while fulfilling responsibilities related to the patient's employment.

Gateway Affiliated Physicians, Hospital and Healthcare Facilities

If ***covered persons*** choose to receive care through Gateway, only those ***physicians, hospitals*** and healthcare ***facilities*** affiliated with Gateway may be selected if the ***covered person*** wishes to receive the global case rate without ***coinsurance.*** A complete listing of Gateway's affiliated ***physicians, hospitals*** and healthcare ***facilities*** may be accessed online at www.gmra.com.

Unaffiliated Physicians, Hospital and Healthcare Facilities

If any of the above covered procedures (case rates) are received from ***physicians, hospitals*** or healthcare ***facilities*** which are not affiliated with Gateway, standard ***Plan*** benefits apply.

Emergency Care

If the ***covered person*** requires ***emergency*** medical treatment and is taken to the nearest appropriate ***hospital*** for any of the above procedures, or the ***covered person*** is scheduled for surgery for any of the above procedures from a provider other than a Gateway provider as of the ***effective date*** of this provision, the ***Plan's*** standard provisions apply.

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan.*** All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable***.*** The ***covered expenses*** for services, supplies or treatment provided must be recommended by a ***physician*** or ***professional provider*** and be ***medically necessary*** care and treatment for the ***illness*** or ***injury*** suffered by the ***covered person.***

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment***.*** The service and applicable ***copay*** are shown on the *Schedule of Benefits.* The ***copay*** must be paid each time a treatment or service is rendered. The ***copay*** will not be applied toward the following:

1. The calendar year deductible.

2. The maximum out-of-pocket expense.

3. The deductible carry-over.

4. The common accident deductible.

DEDUCTIBLES

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible

If, in any calendar year, covered members of a family incur ***covered expenses*** that are subject to the deductible, equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Common Accident

If two or more covered members of a family are ***injured*** in the same accident and, as a result of that accident, incur ***covered expenses,*** only one individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the accident for the remainder of the calendar year.

Deductible Carry-Over

Amounts ***incurred*** during October, November and December and applied toward the deductible of any ***covered person,*** will also be applied to the deductible of that ***covered person*** in the next calendar year.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified in the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

CALENDAR YEAR OUT-OF-POCKET EXPENSE LIMIT

After the ***covered person*** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses*** (after satisfaction of any applicable deductibles), the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for the remainder of the calendar year.

After a covered family has incurred a combined amount equal to the family out-of-pocket expense limit shown on the *Schedule of Benefits,* the ***Plan*** will pay one hundred percent (100%) of ***covered expenses*** for all covered family members for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this ***Plan,*** to include charges in excess of the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable***.***

2. Deductible(s).

3. ***Copays.***

4. Expense ***incurred*** as a result of failure to obtain precertification.

MAXIMUM BENEFIT

The ***maximum benefit*** payable on behalf of a ***covered person*** is shown on the *Schedule of Benefits.* The ***maximum benefit*** applies to the entire time the ***covered person*** is covered under the ***Plan,*** either as an ***employee, dependent, alternate recipient*** or under COBRA. If the ***covered person's*** coverage under the ***Plan*** terminates and at a later date he again becomes covered under the ***Plan,*** the ***maximum benefit*** will include all benefits paid by the ***Plan*** for the ***covered person*** during any period of coverage.

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan.*** All separate ***maximum benefits*** are part of, and not in addition to, the ***maximum benefit.*** No more than the ***maximum benefit*** will be paid for any ***covered person*** while covered by this ***Plan.***

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions and ***inpatient*** and ***outpatient*** surgeries are subject to precertification. Failure to obtain precertification will result in a reduction of benefits, refer to *Utilization Review.*

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units and similar necessary accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** or ***negotiated rate.*** A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person.***

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the ***hospital*** for rendering ***medically necessary*** services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital;***
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the ***hospital);***
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility.***

4. Charges for preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement.*** Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not necessary. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

FACILITY PROVIDERS

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital.***

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such treatment is certified by the attending ***physician*** as ***medically necessary.*** Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. Ambulance service is also covered when ***medically necessary*** to transport the patient from a ***hospital*** or ***ambulatory surgical facility*** to the ***covered person's*** home. (Air ambulance is not covered in this situation.)

ACCIDENT EXPENSE BENEFIT

Initial treatment and follow-up care an ***injury*** will be payable**,** subject to the ***maximum benefit,*** as specified in the *Schedule of Benefits.* ***Covered expenses*** in excess of the ***maximum benefit*** shall be payable under standard ***Plan*** deductible and ***coinsurance*** provisions.

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits. ***Inpatient physician*** visits are limited to one (1) per day.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical allowance for the highest paying procedure, plus fifty (50) percent of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, ***covered expenses*** shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance and the services of a house staff member, intern or resident are not available.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement.*** Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an ***elective surgical procedure*** (non-emergency surgery) is recommended by the ***physician.*** The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

The second surgical opinion benefit includes ***physician*** services and any diagnostic services as may be required.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

TRANSPLANT

Transplant procedures are subject to precertification. Failure to obtain precertification at least five (5) days prior to a transplant procedure shall result in no benefits being payable under this Plan for the transplant procedure.

No benefits shall be payable under this provision of the ***Plan*** for any ***covered person*** until the ***covered person*** completes one (1) year of coverage under this ***Plan.***

Services, supplies and treatments in connection with the listed human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan,*** the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is covered under this ***Plan,*** the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan.*** The donor's expense shall be applied to the recipient's ***maximum benefit.*** In no event will benefits be payable in excess of the ***maximum benefit*** still available to the recipient.

4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan.***

   If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Benefits for organ or tissue transplants are subject to the ***maximum benefit*** shown on the *Schedule of Benefits.* Benefits for organ or tissue acquisition are limited to the ***maximum benefit*** shown on the *Schedule of Benefits.* Benefits for

organ or tissue transplants are payable for ***covered expenses incurred*** during a transplant benefit period which begins five (5) days before the transplant and ends three hundred and sixty-five (365) days after the date of the transplant.

The following are covered transplant procedures: heart, heart-lung, liver, kidney, cornea, bone marrow or pancreas.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***employee,*** a covered female spouse of a covered ***employee,*** and ***dependent*** children.

In the event of early discharge from a ***hospital*** following delivery, the ***Plan*** will cover two (2) Registered Nurse home visits.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** and elective abortions and complications from an abortion.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***employee*** or covered spouse; however, no benefits shall be payable for elective sterilization procedures until the ***covered person*** completes one (1) year of coverage under this ***Plan.*** Reversal of sterilization is not a ***covered expense.***

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care as part of the mother's claim while the mother is confined for delivery.

Such care shall include, but is not limited to:

1. ***Physician*** services

2. ***Hospital*** services

3. Circumcision

INFANT EXAMINATIONS

Covered expenses shall include charges for pediatric examinations which are provided at the earliest feasible time for detection of the following disorders:

1. Phenylketonuria;
2. Hypothyroidism;
3. Hemoglobinopathies, including sickle cell anemia;
4. Galactosemia;
5. Maple syrup urine disease;

6. Homocystinuria;
7. Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8. Physiologic hearing screening examination for the detection of hearing impairment.

In addition, infant examinations for the following shall also be covered:

1. Congenital adrenal hyperplasia;
2. Biotinidase deficiency;
3. Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the state department of insurance determines that the technology is available for use by a designated laboratory.

ROUTINE MAMMOGRAMS

Routine mammograms shall be covered as follows:

1. One (1) baseline mammogram for women age thirty-five (35) through thirty-nine (39);

2. One (1) mammogram every calendar year for women age forty (40) and over.

ROUTINE COLONOSCOPY

One (1) routine colonoscopy per calendar year shall be a ***covered expense*** for ***covered persons*** age fifty (50) and older or earlier if a licensed ***physician*** has determined that risk factors for colon cancer are present.

PREVENTIVE CARE

Covered expenses shall include charges for the services of a ***preferred provider*** for the following preventive services (not due to ***illness*** or ***injury***);

1. Routine physical examination, limited to one (1) per calendar year;

2. Blood cholesterol screening;

3. Pap Smear;

4. Prostate screening; and

5. Well child care for covered ***dependent*** children through age five (5).

THERAPY SERVICES

Outpatient physical, occupational, respiratory and speech therapy services are subject to a ***maximum benefit*** as specified in the *Schedule of Benefits.* Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury,*** for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy, respiratory therapy or speech therapy.

2. Radiation therapy and chemotherapy. ***Outpatient*** IV chemotherapy is subject to precertification.

3. Dialysis therapy or treatment.

4. Infusion therapy. ***Outpatient*** infusion therapy is subject to precertification.

EXTENDED CARE FACILITY

Extended care facility confinement is subject to precertification. ***Extended care facility*** services, supplies and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined in a ***hospital***;

2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement,*** or a related condition;

3. The extended care ***confinement*** begins within twenty-four (24) hours after discharge from that ***hospital confinement;*** and

4. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility)*** limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are limited as shown the *Schedule of Benefits*.

HOME HEALTH CARE

Home health care is subject to precertification. ***Home health care*** enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility. Home health care*** services must be provided according to a ***physician***-prescribed course of treatment. ***Covered expenses*** shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;

2. Physical, respiratory, occupational or speech therapy;

3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;

4. Medical social service consultations;

5. Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary;***

6. Diagnostic services.

HOSPICE CARE

Hospice care is subject to precertification. ***Hospice care*** is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill, and

2. The ***covered person*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board.***

2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

3. Nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.

4. Physical therapy, occupational therapy, respiratory or speech therapy.

5. Nutrition services to include nutritional advice by a registered dietician, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

6. Medical social services.

7. ***Home health aide services.***

8. Medical and surgical supplies.

9. Medical equipment.

10. Laboratory services.

11. Twenty-four (24) hour continuous nursing care (up to three (3) intervals of continuous care, five (5) days per interval).

12. Bereavement counseling as a supportive service to ***covered persons*** in the terminally ill ***covered person's*** immediate family. Benefits will be payable, provided:

    a. On the date immediately before death, the terminally ill person was covered under the ***Plan*** and receiving ***hospice*** care benefits; and

    b. Services shall be limited to a maximum of two (2) visits.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan.*** Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan.***

DURABLE MEDICAL EQUIPMENT

Rental or purchase of ***durable medical equipment*** in excess of one hundred dollars ($100) is subject to precertification. Rental or purchase, whichever is less costly, of necessary ***durable medical equipment*** which is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense.*** Equipment ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A prosthesis ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Repair or replacement of an orthotic device or appliance which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury.*** Treatment must be rendered within seventy-two (72) hours of the ***injury.*** Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall also include ***hospital*** charges for oral surgical procedures (including extraction of teeth) if hospitalization is ***medically necessary*** to safeguard the ***covered person's*** life or health due to a specific non-dental organic impairment.

Covered expenses shall also include charges for the following oral surgical procedures:

1. Removal of full bony impactions;

2. Mandibular staple implant when not done to prepare the mouth for dentures;

3. Maxillary or mandibular frenectomy;

4. Alveolectomy and alveoplasty related to tooth extraction; and

5. Orthognathic surgery if severe handicapping malocclusion is present and proved.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Covered expenses shall include charges for the following services, supplies or treatment of Temporomandibular Joint Dysfunction (TMJ), subject to the ***maximum benefit*** specified on the *Schedule of Benefits**:*** diagnostic services, orthotic or orthopedic devices, adjustments to orthotic or orthopedic devices and therapeutic injections into the temporomandibular joint.

SPECIAL EQUIPMENT AND SUPPLIES

Outpatient medical supplies in excess of two hundred dollars ($200) are subject to precertification. ***Covered expenses*** shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; syringes and needles for diabetes; allergy serums; the initial pair of eyeglasses or contact lenses due to cataract surgery; blood and blood plasma that is not donated or replaced; crutches; electronic pacemakers; oxygen and the administration thereof; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC SURGERY

Cosmetic surgery shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an accident and, as a result requires surgery. ***Cosmetic surgery*** and treatment must be for the purpose of restoring the ***covered person*** to his normal function immediately prior to the accident.

2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

3. It is required as the result of an ***illness*** or previous treatment.

MASTECTOMY

Covered expenses shall include the following:

1. ***Medically necessary*** mastectomy, including complications from a mastectomy, including lymphedemas.

2. Reconstructive breast surgery necessary because of a mastectomy.

3. Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

4. External breast prosthesis and permanent internal breast prosthesis.

MENTAL AND NERVOUS DISORDERS

Inpatient

Subject to the precertification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance,*** up to the ***maximum benefit*** as defined in the *Schedule of Benefits,* for ***confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***mental and nervous disorders.***

Covered expenses shall include:

1. ***Inpatient hospital*** confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Family counseling (counseling with family members to assist in the patient's diagnosis and treatment) – no benefits are payable for marriage counseling;

6. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider.***

Outpatient or Partial Confinement

The ***Plan*** will pay the applicable ***coinsurance,*** up to a ***maximum benefit*** as defined in the *Schedule of Benefits,* for ***outpatient*** services, supplies and treatment related to the treatment of ***mental and nervous disorders.*** One (1) day of ***partial confinement*** will be considered as one (1) ***outpatient*** visit.

Outpatient treatment of ***mental and nervous disorders*** after the fourth visit is subject to precertification.

Covered expenses shall include charges for treatment of Attention Deficit Disorder (ADD) and Attention Deficit/Hyperactivity Disorder (AD/HD).

PERVASIVE DEVELOPMENTAL DISORDER

Covered expenses shall include charges for services, supplies or treatment of pervasive developmental disorders, including Asperger's syndrome and autism, which is prescribed by the patient's attending ***physician*** in accordance with a treatment plan. A "pervasive developmental disorder" is a neurological condition, including Asperger's Syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

CHEMICAL DEPENDENCY

Inpatient

Subject to the precertification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance,*** up to the ***maximum benefit*** as defined in the *Schedule of Benefits,* for ***confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***chemical dependency.***

Covered expenses shall include:

1. ***Inpatient hospital*** confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Family counseling (counseling with family members to assist in the patient's diagnosis and treatment) – no benefits are payable for marriage counseling;

6. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider.***

Outpatient or Partial Confinement

The ***Plan*** will pay the applicable ***coinsurance,*** up to a ***maximum benefit*** as defined in the *Schedule of Benefits,* for ***outpatient*** services, supplies and treatment related to the treatment of ***chemical dependency.*** One (1) day of ***partial confinement*** will be considered as one (1) ***outpatient*** visit.

Outpatient treatment of ***chemical dependency*** after the fourth visit is subject to precertification.

ORTHOPTIC THERAPY

Covered expenses shall include charges for orthoptic therapy rendered by a ***physician*** or other ***professional provider*** in a ***physician's*** office, in the ***outpatient*** department of a ***hospital*** or other ***outpatient facility*** that is organized and operated to provide such services.

OUTPATIENT PAIN MANAGEMENT

Covered expenses shall include charges for ***outpatient*** pain management programs conducted by a ***physician*** or other ***professional provider*** in a ***physician's*** office, the ***outpatient*** department of a ***hospital,*** or other ***outpatient facility*** that is organized and operated to provide such services. For the purposes of this ***Plan,*** a "pain management program" is a program which is conducted under the supervision of the patient's attending ***physician*** and established for the purpose of training the patient to control and management pain.

PRIVATE DUTY NURSING

Services of a Registered Nurse or Licensed Practical Nurse for private duty ***nursing*** shall be a ***covered expense*** when ordered by a ***physician,*** subject to the ***maximum benefit*** specified on the *Schedule of Benefits.* Nursing services do not include care which is primarily non-medical or ***custodial*** in nature, such as bathing, exercising and feeding.

CHIROPRACTIC CARE

Covered expense includes services of a ***preferred provider*** for ***chiropractic care*** including initial consultation, manipulation techniques, physical therapy techniques, x-rays and other ***medically necessary*** treatment, subject to the ***maximum benefit*** specified on the *Schedule of Benefits.*

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures of dislocations of bones of the foot.

SURGICAL TREATMENT OF MORBID OBESITY

Covered expenses shall include charges for surgical treatment of ***morbid obesity*** for ***covered persons*** with health problems which are aggravated by or related to the ***morbid obesity,*** including, but not limited to gastric by-pass, gastric stapling or gastric balloon.

OUTPATIENT TREATMENT OF SLEEP APNEA

Covered expenses shall include charges for ***outpatient*** treatment of sleep apnea, subject to the precertification provisions of the ***Plan.***

PATIENT EDUCATION

Covered expenses shall include ***medically necessary*** patient education programs including, but not limited to diabetic education and ostomy care; however such programs shall only be covered if they are not offered through the Disease Education Program.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a ***professional provider; physician; hospital; facility*** or any other health care provider shall be a ***covered expense*** under the terms of the ***Plan.***

REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified cardiac/pulmonary rehabilitation programs.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for ***pre-existing conditions*** as specified in *Effective Date of Coverage, Pre-existing Conditions.*

2. Charges for services, supplies or treatment for the reversal of sterilization procedures.

3. Charges for services, supplies or treatment related to the diagnosis or treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

4. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

5. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

6. Charges for marital counseling.

7. Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

8. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses; dispensing optician's services.

9. Charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

10. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician,*** such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

11. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic Surgery*.

12. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs.

13. Charges for surgical weight reduction procedures and all related charges, except as specified herein.

14. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid.

15. Charges for routine physical examinations, such as screening examination, employment physical, or any related charges, such as premarital lab work, and other care not associated with treatment or diagnosis of an ***illness*** or ***injury,*** except as specified herein.

16. Charges for ***custodial care,*** domiciliary care or rest cures.

17. Charges for environmental change including ***hospitalization*** or ***physician*** charges connected with prescribing an environmental change.

18. Charges for any services, supplies or treatment not specifically provided herein.

19. Charges for x-ray examinations without film.

20. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests or physical therapy, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary.***

21. Charges for travel or accommodations, whether or not recommended by a ***physician,*** except as specifically provided herein.

22. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness.

23. Charges for expenses related to hypnosis.

24. Charges for prescription drugs that are covered under the *Prescription Drug Program* or for the Prescription Drug ***copay*** applicable thereto.

25. Charges for professional services billed by a ***physician*** or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

26. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example.)

27. Charges for treatment or surgery for sexual dysfunction or inadequacy**.**

28. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

29. Charges for services, supplies or treatment for development delay, learning disorders, mental retardation or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the ***illness*** shall be a ***covered expense.***

30. Charges for biofeedback therapy.

31. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

32. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

33. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts, unless ***medically necessary***.

34. Charges ***incurred*** as a result of, or in connection with, ***cosmetic surgery*** or any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications.

35. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

36. Charges related to acupuncture treatment.

37. Charges for chelation therapy, except as treatment of heavy metal poisoning.

38. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.

39. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

40. Charges for holistic medicines or providers or naturopathy.

41. Charges for or related to the following types of treatment:

a. primal therapy;
b. rolfing;
c. psychodrama;
d. megavitamin therapy;
e. visual perceptual training.

42. Charges for structural changes to a house or vehicle.

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with the ***Plan*** to charge ***covered persons*** reduced fees for covered prescription drugs.

COPAY

The ***copay*** is applied to each covered pharmacy drug charge and is shown on the S*chedule of Benefits*. The ***copay*** amount is not a ***covered expense*** under the *Medical Expense Benefit.* Any one prescription is limited to a thirty (30) day supply and one (1) refill.

If a drug is purchased from a ***nonparticipating pharmacy,*** the ***covered person*** must pay the entire cost of the prescription, including ***copay,*** and then submit the receipt to the prescription drug card vendor for reimbursement. The ***covered person*** will be responsible for the ***copay,*** plus the twenty-five percent (25%) of the ***nonparticipating pharmacy*** billed amount.

If no ***generic*** equivalent drug is available for a prescription, the ***covered person*** will be responsible only for the ***copay*** applicable to a ***generic drug.***

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer ***covered persons*** significant savings on prescriptions.

Maintenance drugs must be purchased through the *Mail Order Option.*

If no ***generic*** equivalent drug is available for a prescription, the ***covered person*** will be responsible only for the ***copay*** applicable to a ***generic drug.***

COPAY

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits.* It is not a ***covered expense*** under the *Medical Expense Benefit.* Any one prescription is limited to a ninety (90) day supply.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except drugs excluded by the ***Plan.***

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin when prescribed by a ***physician.***

4. Oral contraceptives.

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician.***

2. Refills up to one year from the date of order by a ***physician.***

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

3. Immunization agents or biological sera; blood or blood plasma.

4. A drug or medicine labeled: "Caution - limited by federal law to investigational use."

5. Experimental drugs and medicines, even though a charge is made to the ***covered person.***

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital confined.*** This includes being confined in any institution that has a facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for insulin syringes and/or needles when prescribed alone or needles and syringes for other than diabetic use.

11. A charge for contraceptive devices.

12. A charge for any prescription used for treatment only to improve appearance.

13. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches.

14. A charge for appetite suppressants.

DENTAL EXPENSE BENEFIT

Subject to all the terms of the ***Plan,*** the ***Plan*** will pay a dental benefit for covered dental expenses ***incurred*** by a ***covered person.*** The dental benefit is a percentage of the ***customary and reasonable amount*** for ***incurred*** covered dental expenses, as shown on the *Schedule of Benefits*.

LATE ENROLLMENT

Coverage for dental expense benefits will be subject to this late enrollment provision if the ***employee*** fails to enroll himself and/or his eligible ***dependents*** within thirty-one (31) days of becoming eligible for coverage or within thirty-one (31) days of a Special Enrollment Period.

Late enrollment shall result in dental coverage being limited as follows:

1. During the first twelve (12) months of coverage under the ***Plan,*** coverage shall be limited to *Class I - Preventive Dental Services.*

PREDETERMINATION OF BENEFITS

"Predetermination of benefits" means that the ***dentist*** submits a dental treatment plan to the ***claims processor*** before treatment starts for:

1. Any basic or major treatment expected to result in charges for covered dental expenses of three hundred dollars ($300) or more; and

2. For all orthodontic treatment.

The ***claims processor*** will inform the ***covered person*** the level of benefits from the ***Plan*** for the covered dental services, supplies and treatments recommended. This pre-estimate is not an agreement for payment of the dental expenses.

DEDUCTIBLE

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must incur during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible

When three (3) covered members of the same family have each met their individual deductible amount during a calendar year, the family deductible amount shall be considered satisfied for that calendar year and no further deductible amount shall be taken from the expenses of any covered family member for the remainder of that calendar year.

COINSURANCE

The ***Plan*** pays a specified percentage of the ***customary and reasonable amount*** for ***covered expenses.*** That percentage is listed on the *Schedule of Benefits.* The ***covered person*** is responsible for the difference.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a ***covered person*** for covered dental expense is stated on the *Schedule of Benefits.* If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the calendar year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan.***

The ***maximum benefit*** for orthodontic treatment while a ***covered person*** is covered by this ***Plan*** is also shown on the *Schedule of Benefits.*

ALTERNATIVE TREATMENT

In the event the ***dentist*** recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the ***covered person's*** choice to obtain the higher-cost treatment will be the ***covered person's*** responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred,*** except as follows:

1. For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;

2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;

3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Class I - Diagnostic and Preventive Dental Services

Oral Evaluation (Examination) and Prophylaxis (Cleaning): Oral evaluations are limited to two (2) per calendar year. Prophylaxis is limited to twice per calendar year. Fluoride application is limited to once in any twelve (12) month period.

1. Periodic oral evaluation.
2. Limited oral evaluation, problem focused.
3. Comprehensive oral evaluation.

4. Detailed and extensive oral evaluation, problem focused, by report.
5. Prophlyaxis for ***covered persons*** age twelve (12) and older, treatment to include scaling and polishing.
6. Prophylaxis for ***covered persons*** under age twelve (12).
7. Topical application of fluoride with prophylaxis (for children under age nineteen).
8. Topical application of fluoride without prophlyaxis (only for children under age nineteen).
9. Sealant, per tooth (once in any thirty-six (36) month period, only for permanent molars, only for children at least six(6) but less than sixteen (16) years of age).

X-rays

1. Intraoral, complete series (including any bitewings) – only one of the two procedures (0210 or 0330) will be covered in any thirty-six (36) month period..
2. Intraoral, periapical, first film.
3. Intraoral, periapical, each additional film, (benefits for a single series of 0220 and 0230 films, including any bitewings, not to exceed benefit for a single 0210 series.)
4. Intraoral, occlusal film.
5. Extraoral, first film.
6. Extraoral, each additional film.
7. Bitewings, single film – only two (2) series of bitewings will be covered per calendar year.
8. Bitewings, two films – only two (2) series of bitewings will be covered per calendar year.
9. Bitewings, four films – only two series of bitewings will be covered per calendar year.
10. Posterior/anterior/lateral skull and facial bone survey,
11. Panoramic film, only one of the two procedures (0210 or 0330) will be allowed in any thirty-six (36) month period.)

Other Diagnostic Services

1. Pulp vitality tests.
2. Diagnostic casts.
3. Diagnostic photographs.

Space Maintainers – Fee includes all adjustments within six (6) months after installation. Allowable only for the purpose of maintaining spaces created by extractions of primary teeth or unerupted teeth.

1. Fixed space maintainer, unilateral.
2. Fixed space maintainer, bilateral.
3. Removable space maintainer, unilateral.
4. Removable space maintainer, bilateral.
5. Recementation of space maintainer.

Class II - Basic Dental Services

Basic Restorations (Fillings) - excluding inlays, onlays, crowns and bridges)

1. Amalgam restorations.
   One surface, primary
   Two surfaces, primary
   Three surfaces, primary
   Four or more surfaces, primary
   One surface, permanent
   Two surfaces, permanent
   Three surfaces, permanent
   Four or more surfaces, permanent
2. Silicate cement restorations.

Per restoration

3. Resin restorations – benefit for resin restoration of a posterior tooth not to exceed benefit for amalgam restoration of the same tooth involving the dame number of surfaces.
   One surface, anterior
   Two surfaces, anterior
   Three surfaces, anterior
   Four or more surfaces or involving incisal angle, anterior
   Composite resin crown, anterior primary tooth
   One surface, posterior primary
   Two surfaces, posterior primary
   Three or more surfaces, posterior primary
   One surface, posterior permanent
   Two surfaces, posterior permanent
   Three or more surfaces, posterior permanent

Recementation.

1. Inlay.
2. Crown.
3. Bridge.

Basic Endodontics – including necessary x-rays and cultures, but excluding final restoration

1. Endodontic therapy, limited to use on primary teeth only.
   Direct pulp cap
   Indirect pulp cap
   Therapeutic pulpotomy
   Resorbable, filling pulpal therapy, anterior
   Resorbable, filling pulpal therapy, posterior
2. Root canals, limited to use on permanent teeth only
   Anterior, one canal
   Bicuspid, two canals
   Molar, three canals
   Retreatment of previous root canal therapy, anterior
   Retreatment of previous root canal therapy, bicuspid
   Retreatment of previous root canal therapy, molar

Denture Repairs

1. Repair or complete dentures.
   Repair of broken base
   Replace missing or broken teeth, each tooth
2. Repair of, or additions to, partial dentures
   Repair resin base
   Repair cast framework
   Repair or replace broken clasp
   Replace broken tooth, per tooth
   Add tooth to existing partial
   Add clasp to existing partial

Oral Surgery

1. Simple extractions.
   Single tooth
   Each additional tooth
   Root removal, exposed roots
2. Surgical extractions.
   Surgical removal of erupted tooth requiring elevator or mucoperiosteal flap and removal of bone and or section of tooth
3. Impacted Teeth.
   Removal of impacted tooth, soft tissue
   Removal of impacted tooth, partially bony
   Removal of impacted tooth, completely bony
   Removal of impacted tooth, completely bone, with unusual surgical complications
4. Removal of cysts and neoplasms.
   Biopsy of oral tissue, hard
   Biopsy of oral tissue, soft
   Radical excision of lesion, up to 1.25 cm.
   Radical excision of lesion, over 1.25 cm.
   Excision of benign tumor, up to 1.25 cm
   Excision of benign tumor, over 1.25 cm
   Excision of malignant tumor, up to 1.25 cm
   Excision of malignant tumor, over 1.25 cam
   Removal of odontogenic cyst or tumor, up to 1.25 cm
   Removal of odontogenic cyst or tumor, over 1.25 cm
   Removal of nonodontogenic cyst or tumor, up to 1.25 cm
   Removal of nonodontogenic cyst or tumor, over 1.25 cm
   Destruction of lesion(s) by physical or chemical method, by report
   Incision and drainage of abscess, intraoral soft tissue
   Incision and drainage of abscess, extraoral soft tissue
5. Other oral surgical procedures.
   Surgical removal of residual tooth roots (cutting procedures)
   Tooth re-impantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus
   Tooth transplantation 9includes re-implantation from one site to another and splinting and/or stabilization)
   Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)
   Surgical exposure of impacted or unerupted tooth to aid eruption
   Surgical repositioning of teeth
   Transseptal fiberotomy, by report
   Frenulectomy (frenectomy or frenotomy) as a separate procedure

Anesthesia – when administered by the ***dentist*** in the ***dentist's*** office (not covered unless a cutting procedure is performed at that time)

1. General anesthesia.
2. Intravenous sedation.

Treatment Plan

1. Sedative filling.
2. Emergency palliative for dental pain, minor procedure.

Class III - Major Dental Expenses

Major Restorations (Foil, Inlays, Onlays, Crowns) - covered only when needed due to decay of traumatic ***injury***

1. Foil, inlays and onlays.
   - Gold foil, one surface
   - Gold foil, two surfaces
   - Gold foil, three or more surfaces
   - Inlay, metallic, one surface
   - Inlay, metallic, two surfaces
   - Inlay, metallic, three or more surfaces
   - Onlay, metallic, three surfaces
   - Onlay, metallic, four or more surfaces
   - Inlay, porcelain/ceramic, one surface
   - Inlay, porcelain/ceramic, two surfaces
   - Inlay, porcelain/ceramic, three or more surfaces
   - Onlay, porcelain/ceramic, two surfaces
   - Onlay, porcelain/ceramic, three surfaces
   - Onlay, porcelain/ceramic, four or more surfaces
   - Inlay, composite/resin, one surface (laboratory processed)
   - Inlay, composite/resin, two surfaces (laboratory processed)
   - Inlay, composite/resin, three or more surfaces (laboratory processed)
   - Onlay, composite/resin, two surfaces (laboratory processed)
   - Onlay, composite/resin, three surfaces (laboratory processed)
   - Onlay, composite/resin, four or more surfaces (laboratory processed)
2. Crowns and Related Procedures.
   - Resin
   - Resin with high noble metal
   - Resin with predominantly base metal
   - Resin with noble metal
   - Porcelain/ceramic substrate
   - Porcelain fused to high noble metal
   - Porcelain fused to predominantly base metal
   - Porcelain fused to noble metal
   - High noble metal, full cast
   - Predominantly base metal, full cast
   - Noble metal, full cast
   - Metallic, ¾ cast
   - Prefabricated stainless steel, primary tooth
   - Prefabricated stainless steel, permanent tooth (available to children under age nineteen (19) only)
   - Prefabricated resin crown (available to children under age nineteen (19) only)
   - Prefabricated stainless steel crown with resin window (available to children under age nineteen (19) only)
   - Core build-up, including any pins
   - Pin retention, per tooth, in addition to restoration
   - Cast post and core in addition to crown
   - Prefabricated post and core in addition to crown
   - Post removal, not in conjunction with endodontic therapy

Major Endodontics – endodontic surgical procedures include any local anesthesia and routine post-operative visits.

1. Apexification/recalcification, initial visit.
2. Apexification/recalcification, interim visit.
3. Apexification/recalcification, final visit.
4. Apicoectomy/periradicular surgery, anterior (single root).

5. Apicoectomy/periradicualr surgery, bicuspid, first tooth.
6. Apicoectomy/periradicular surgery, molar, first root.
7. Apicoectomy/periradicular surgery, bicuspid or molar, each additional tooth.=
8. Retrograde filling, per root.
9. Root amputation, per root.
10. Endodontic osseous implant.
11. Intentional replantation, including necessary splinting.
12. Hemisection, including any root removal but not including root canal therapy.

Periodontics – periodontic surgical procedure include any local anesthesia and routine post-operative visits.

1. Periodontal examination.
2. Gingivectomy or gingivoplasty, per quadrant.
3. Gingivectomy or gingivoplasty, per tooth (fewer than six (6) teeth).
4. Gingival curettage, surgical, per quadrant, be report – requires presence of periodontal disease as confirmed by both x-rays and pocket depth summaries of each tooth involved.
5. Gingival flap procedure, including root planing, per quadrant.
6. Clinical crown lengthening, hard tissue.
7. Mucogingival surgery, per quadrant.
8. Osseous surgery, including flap entry and closure, per quadrant.
9. Bone replacement graft, first site in quadrant.
10. Bone replacement graft, each additional site in quadrant.
11. Guided tissue regeneration, resorbable barrier, per site, per tooth.
12. Guided tissue regeneration, nonresorbable barrier, per site, per tooth (includes membrane removal).
13. Pedicle soft tissue graft procedure.
14. Free soft tissue graft procedure, including donor site surgery.
15. Subepithelial connective tissue graft procedure, including donor site surgery.
16. Distal or proximal wedge procedure when not performed in conjunction with surgical procedures in the same anatomical area.
17. Provisional splinting, intracoronal.
18. Provisional splinting, extracoronal.
19. Periodontal scaling and root planing, per quadrant – requires presence of periodontal disease as confirmed by both x-rays and pocket depth summaries of each tooth involved.
20. Full mouth débridement to enable comprehensive periodontal evaluation and diagnosis.
21. Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue.
22. Periodontal maintenance procedure following active therapy.

Removable Prosthodontics (Partial and Complete Dentures) – Fees for both partial and complete dentures and relining include adjustments within six (6) months after installation. Relines are not covered until more than six (6) months after installation. Adjustments are not covered as a separate procedure until more than six (6) months after installation. Precision attachments, overdentures, specialized techniques, and characterizations are considered optional and the additional expense for these is not covered. All partials include conventional clasps, rests and teeth.

1. Complete upper denture.
2. Complete lower denture.
3. Immediate upper denture.
4. Immediate lower denture.
5. Upper partial, resin base.
6. Lower partial, resin base.
7. Removable unilateral partial, one piece cast metal.
8. Adjust complete upper denture.
9. Adjust complete lower denture.
10. Adjust upper partial.
11. Adjust lower partial.

12. Rebase complete upper denture.
13. Rebase complete lower denture.
14. Rebase upper partial.
15. Rebase lower partial.
16. Office reline, complete upper denture.
17. Office reline, complete lower denture.
18. Office reline, upper partial.
19. Office reline, lower partial.
20. Lab reline, complete upper denture.
21. Lab reline, complete lower denture.
22. Lab reline, upper partial.
23. Lab reline, lower partial.
24. Complete overdenture, by report – benefit not to exceed benefit for corresponding denture (complete or partial, upper or lower).
25. Partial overdenture, by report - benefit not to exceed benefit for corresponding denture (complete or partial, upper or lower).

Fixed Prosthodontics (Bridges)

1. Pontics.
   Cast high noble metal
   Cast predominantly base metal
   Cast noble metal
   Porcelain fused to high noble metal
   Porcelain fused to predominantly base metal
   Porcelain fused to noble metal
   Resin with high noble metal
   Resin with predominantly base metal
   Resin with noble metal
2. Retainers.
   Inlay, metallic, two surfaces
   Inlay, metallic, three or more surfaces
   Onlay, metallic, three surfaces
   Onlay, metallic, four or more surfaces
   Cast metal, for resin bonded fixed prosthesis (bridge to include maximum of one pontic and two metal retainers)
   Crown, resin with high noble metal
   Crown, resin with predominantly base metal
   Crown, resin with noble metal
   Crown, porcelain fused to high noble metal
   Crown, porcelain fused to predominantly base metal
   Crown, porcelain fused to noble metal
   Crown, ¾ cast high noble metal
   Crown, full cast high noble metal
   Crown, full cast predominantly base metal
   Crown, full cast noble metal
   Stress breaker
   Cast post and core in addition to bridge retainer
   Cast post as part of bridge retainer
   Prefabricated post and core in addition to bridge retainer
   Core build-up for retainer, including any pins
   Metal coping

Other Major Services

1. Repairs, crowns and bridges.
   Crown repair, by report
   Bridge repair, by report
2. Alveolar or gingival reconstruction, including any local anesthesia and routine post-operative visit
3. Alveoplasty, in conjunction with extractions, per quadrant.
4. Alveoplasty not in conjunction with extractions, per quadrant.
5. Vestibuloplasty, ridge extension (secondary epithelialization).
6. Vestibuloplasty, ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hyperplastic tissue).
7. Excision of hyperplastic tissue, per arch.
8. Excision of pericoronal gingiva.

Class IV - Orthodontic Services (for ***dependent*** children under age 19 only)

1. Limited orthodontic treatment of the permanent denture.
2. Comprehensive orthodontic treatment of the permanent dentition.
3. Orthodontic monthly adjustment.
4. Pre-orthodontic treatment visit.
5. Periodic orthodontic treatment (as part of contract).
6. Orthodontic treatment (alternative billing to a contract fee).

NON-COVERED DENTAL PROCEDURES

1. Saliography.
2. Temporomandibular join (TMJ), arthrogram, including injection.
3. X-rays, other temporomandibular joint (TMJ) films, by report.
4. X-rays, tomographic survey.
5. X-rays, cephalometric film.
6. Sterilization or infection control, or bacteriologic studies for determination of pathologic agents.
7. Caries susceptibility test.
8. Histopathologic examination.
9. Other oral pathology procedures, by report.
10. Topical application of fluoride for ***covered persons*** age nineteen (19) and older.
11. Nutritional counseling for the control or prevention of dental disease.
12. Tobacco counseling for the control or prevention of oral disease.
13. Oral hygiene instruction.
14. Labial veneers.
15. Temporary crown (for fractured tooth).
16. Surgical procedure for isolation of tooth with rubber dam.
17. Canal preparation and fitting of preformed dowel or post.
18. Bleaching of discolored tooth.
19. Unscheduled dressing change by someone other than the treating ***dentist.***
20. Interim dentures.
21. Tissue conditioning.
22. Precision attachment, by report.
23. Various prostheses and related procedures.
24. Various implants and related procedures.
25. Connector bar.
26. Precision attachment.
27. Removal of exotoses, maxilla or mandible.
28. Partial ostectomy (guttering or saucerization).
29. Radical resection of mandible with bone graft.

30. Removal of foreign body, skin or subcutaneous tissue.
31. Removal of reaction-producing foreign bodies from musculo-skeletal system.
32. Sequestrectomy for osteomyelitis.
33. Maxillary sinusotomy for removal of tooth fragment or foreign body.
34. Various procedures for reduction of fractures.
35. Various procedures related to the temporomandibular joint.
36. Suture of wounds.
37. Skin grafts.
38. Various osteoplastic, osteotomic, and grafting procedures for repair of defects.
39. Repair or maxillofacial soft and hard tissue defect.
40. Various procedures related to the salivary gland.
41. Emergency tracheotomy.
42. Coronoidectomy.
43. Synthetic graft, mandible or facial bones, by report.
44. Mandible implant for augmentation purposes (excluding alveolar ridge) by report.
45. Orthodontic treatment of the primary or transitional dentition.
46. Appliance therapy to control harmful habits.
47. Orthondontic retention (removal of appliances, construction and placement of retainers).
48. Local anesthesia not in conjunction with operative or surgical procedures.

DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this ***Plan*** for dental expenses ***incurred*** by a ***covered person*** for the following:

1. Any treatment which is for cosmetic purposes, or to correct a congenital malformation, other than ***medically necessary*** treatment of congenital cleft in the lip or palate, or both.

2. To replace any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five (5) years of the date of the last placement of these items., unless replacement is required dye to an accidental bodily ***injury.***

3. For initial placement of any prosthetic appliance or fixed bridge unless such placement is needed because of the extraction of one (1) or more natural teeth; however, the extraction of a third molar (wisdom tooth) does not qualify under the above. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth.

4. Any procedure which began before the date the ***covered person's*** dental coverage started to include a service which is:

    a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
    b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
    c. Root canal therapy, for which the pulp chamber was opened before such person became covered.

    X-rays and prophylaxis shall not be deemed to start a dental procedure.

5. Charges for any device ordered while the individual was covered under this ***Plan*** and not delivered or installed within ninety (90) days after termination of coverage.

6. To replace lost, missing or stolen appliances or prosthetic devices.

7. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.

8. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called or to treat disturbances of the temporomandibular joint.

9. Any procedure not listed under *Covered Dental Expense*.

10. For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.

11. For sealants which are:
    a. not applied to a permanent molar;
    b. applied to ***covered persons*** over seventeen (17) years of age;
    c. reapplied to a molar within three (3) years of a previous sealant application.

12. For any services related to equilibration, bite registration or bite analysis.

13. For crowns for the purpose of periodontal splinting.

14. Charge for implants, except as specified herein; precision or semi-precision attachments and endodontic treatment associated with it; other customized attachments.

15. A service not furnished by a ***dentist,*** except:

    a. That performed by a licensed dental hygienist under a ***dentist's*** supervision;
    b. X-rays ordered by a ***dentist.***

16. Replacement of a prosthetic which in the ***dentist's*** opinion can be repaired or does not need replacement.

17. Charges resulting from changing from one ***dentist*** to another while receiving treatment, or from receiving care from more than one ***dentist*** for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one ***dentist*** had performed all the required dental services.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider.***

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, supplies or treatment for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury,*** or which are not recommended and approved by the attending ***physician,*** except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount*** or exceed the ***negotiated rate*** as applicable.

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during the ***covered person's*** commission or attempted commission of a criminal battery or felony. Claims shall be denied if the ***plan administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the ***covered person***.

8. To the extent that payment under this ***Plan*** is prohibited by any law of the jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred.***

9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage, except as specified herein.

10. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

11. Charges for services, supplies or treatment that is considered ***experimental/investigational.***

12. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person.***

13. Charges for services, supplies or treatment rendered by physicians or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider.***

14. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation.*

15. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in *Claim Filing Procedures.*

16. Charges for e-mail or telephone consultations, completion of claim forms, charges associated with missed appointments.

17. Charges for services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group.

18. If the primary plan has a restricted list of healthcare providers and the ***covered person*** chooses not to use a provider from the primary plan's restricted list, this ***Plan*** will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.

19. This ***Plan*** will not pay for any charge which has been refused by another plan covering the ***covered person*** as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

20. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

21. Benefits which are payable under any one section of this ***Plan*** shall not be payable as a benefit under any other section of this ***Plan.*** For example, if a benefit is eligible under both the *Medical Expense Benefit* section and the *Dental Expense Benefit* section, and is paid under the *Medical Expense Benefit,* the remaining balance will **not** be paid under the *Dental Expense Benefit.*

ELIGIBILITY

This section identifies the ***Plan's*** requirements for a person to be eligible to enroll. Refer to *Enrollment* and *Effective Date of Coverage* for more information.

EMPLOYEE ELIGIBILITY

All ***full-time employees*** regularly scheduled to work at least thirty (30) hours per work week and appointed or elected officials shall be eligible to enroll for coverage under this ***Plan.*** This does not include temporary or seasonal ***employees.***

Retired employees who meet all eligibility requirements as specified by state statute or city ordinance may continue coverage by paying the applicable contribution for ***employee*** and/or ***dependent*** coverage. While the ***employer*** expects ***retiree*** coverage to continue, the ***employer*** reserves the right to modify or discontinue ***retiree*** coverage at any time.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***employer*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, a child who has been placed in the custody of a covered ***employee*** or spouse pursuant to an interlocutory order of adoption, and a child for whom the ***employee*** or covered spouse has been appointed legal guardian, provided:
   a. The child has not reached the end of the calendar year of his or her nineteenth (19^{th}) birthday, and;
   b. The child is unmarried, and;
   c. The child is principally dependent upon the ***employee*** for support and maintenance.

3. Upon written notice to the ***employer,*** a child who has reached the end of the calendar year of his or her nineteenth (19th) birthday and is principally dependent upon the ***employee*** for support and maintenance, may also be included herein as an eligible ***dependent*** until the end of the calendar year of the child's twenty-fifth (25th) birthday, provided such child is unmarried, and is a ***full-time student*** in a secondary school, accredited college, university or institution of higher learning. It is the ***employee's*** responsibility to provide the ***claims processor*** with proof of ***full-time student status*** for each semester. The ***employee*** must notify the ***employer*** when the ***dependent*** is no longer a ***full-time student.***

4. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***employee*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or other loss of ***dependent's*** eligibility, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor,*** but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental and/or physical disability;

   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible ***employee*** may enroll eligible ***dependents.*** However, if both the husband and wife are ***employees,*** they may choose to have one covered as the ***employee,*** and the spouse covered as the ***dependent*** of the ***employee,*** or they may choose to have both covered as ***employees.*** Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

ENROLLMENT

APPLICATION FOR EMPLOYEE OR DEPENDENT ENROLLMENT

An ***employee*** must file a written application with the ***employer*** for coverage hereunder for himself and his eligible ***dependents*** within thirty-one (31) days of his ***effective date*** for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder. Applications for enrollment must be received by the ***claims processor*** within forty-five (45) days of the ***effective date*** of coverage.

The ***employer*** must be notified of any change in eligibility of ***dependents,*** including the birth of a child that is to be covered and adding or deleting any other ***dependents.*** Forms are available from the ***employer*** for reporting changes in ***dependents'*** eligibility as required.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)

2. Cessation of employer contributions toward the other coverage or a significant change in cost

3. Legal separation or divorce

4. Termination of other employment or reduction in number of hours of other employment

5. Death of ***covered person.***

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage. The ***claims processor*** must receive the enrollment application no later than forty-five (45) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day following the date of termination of other coverage.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An ***employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

The ***employee*** must request the special enrollment within thirty-one (31) days of the acquisition of the ***dependent.*** The enrollment application must be submitted to the ***claims processor*** within forty-five (45) days of the date of acquisition of the ***dependent.***

The effective date of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the date of marriage;

2. in the case of a ***dependent's*** birth, the date of such birth;

3. in the case of adoption or ***placement for adoption***, the date of such adoption or ***placement for adoption***.

OPEN ENROLLMENT

Open enrollment is the period designated by the ***employer*** during which the ***employee*** may elect coverage for himself and any eligible ***dependents*** if he is not covered under the ***Plan*** and does not qualify for a Special Enrollment as described herein. An open enrollment will be permitted once in each calendar year during the months of November and December. ***Employees*** or ***dependents*** who enroll in the ***Plan*** during an open enrollment are considered ***late enrollees***.

During this open enrollment period, an ***employee*** and his ***dependents*** who are not covered under this ***Plan*** must complete and submit an enrollment form for coverage. Coverage shall be effective on the following January 1.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

Eligible ***employees,*** as described in *Eligibility,* are covered under the ***Plan*** as follows:

1. For elected or appointed officials, the date the official takes office;

2. For ***full-time employees,*** the first of the month coincident with or following completion of ninety (90) days of ***full-time*** employment.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s),*** as described in *Eligibility,* will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has completed the proper enrollment procedures.

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of the date acquired (enrollment application submitted to the ***claims processor*** within forty-five (45) days of the date acquired).

3. Newborn children shall be covered from birth, regardless of ***confinement,*** provided the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of birth and enrollment application submitted to the ***claims processor*** within forty-five (45) days of the date of birth.

PRE-EXISTING CONDITIONS

Benefits will be provided for ***pre-existing conditions*** after the completion of a period of nine (9) months (fifteen (15) months for a ***late enrollee***) from the ***covered person's*** date of enrollment for coverage under this ***Plan.*** For the purpose of this provision, the date of enrollment shall mean the first day of any applicable service waiting period or the date of hire. For enrollment due to a Special Enrollment Period or Open Enrollment Period, the date of enrollment is the first day of coverage.

This ***pre-existing condition*** limitation shall not apply to a child born to or ***placed for adoption*** after the ***employee's effective date*** of coverage under this ***Plan,*** nor to ***pregnancy*** under any circumstances.

Precertification from the ***Utilization Review Organization*** does not constitute ***Plan*** liability for any ***pre-existing condition*** charges during this waiting period.

For the purpose of determining whether this ***pre-existing condition*** provision of the ***Plan*** will be applied to claims for any individual, the ***Plan administrator*** will look not only to the period of time the individual has been covered under this ***Plan,*** but also to any period of previous creditable coverage the individual has earned. Creditable coverage shall include, but is not limited to, coverage the individual may have had under a prior employer's benefit plan or COBRA, individual or group insurance, Medicare or Medicaid, a state risk pool, or TriCare. Other types of coverage may also be considered creditable coverage. However, creditable coverage will only be applied to this ***Plan's pre-existing condition*** time periods if there has been no break in coverage of the individual for more than sixty-three days. If there has been a break in coverage of more than sixty-three days, the ***Plan administrator*** will not apply previous coverage towards this ***Plan's pre-existing condition*** limitation. Waiting periods for coverage do not count as a break in coverage.

It is the ***employee's*** responsibility to provide the ***Plan administrator*** with evidence of creditable coverage. Such evidence may be in the form of a Certificate of Coverage or in any other form acceptable to the ***Plan administrator.***

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) provision or as specified herein, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The last day of the month in which the ***employee*** ceases to meet the eligibility requirements of the ***Plan.***

3. The last day of the month in which employment terminates.

4. The date the ***employee*** becomes a ***full-time,*** active member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.

DEPENDENT(S) TERMINATION DATE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee's*** coverage terminates. However, if the ***employee*** remains eligible for the ***Plan,*** but elects to discontinue coverage, coverage may be extended for ***alternate recipients.***

3. The date such person ceases to meet the eligibility requirements of the ***Plan.***

4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. Cessation of ***full-time student status*** for ***dependent*** children age nineteen (19) or older shall terminate coverage on the earliest of the following dates:

    a. The last date of the calendar year in which the ***dependent*** is no longer a ***full-time student.***
    b. The date the school reconvenes after school vacation, if the ***dependent*** fails to meet the ***full-time student*** criteria.
    c. The last day of the calendar year following graduation.
    d. The date the ***dependent*** reaches the maximum age limit as stated in *Eligibility*.

6. The date the ***dependent*** becomes a ***full-time,*** active member of the armed forces of any country.

7. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents.***

8. The date the ***dependent*** becomes eligible as an ***employee.***

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is on an authorized non-FMLA ***leave of absence*** from the ***employer.*** In no event will coverage continue beyond the end of the month in which the ***employee's*** active service ends.

For an FMLA eligible ***leave of absence,*** coverage may be continued for a period of up to six (6) months after the ***employee's*** active service ends.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents,*** when the ***employee*** is subject to an ***employer layoff.*** In no event will coverage continue beyond the end of the month in which the ***employee's*** active service ends.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this ***Plan*** for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan.*** The ***employee*** shall be responsible to continue payment for eligible ***dependent's*** coverage and any remaining ***employee*** contributions. If the covered ***employee*** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work***.***

Repayment Requirement

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

CONTINUED COVERAGE OF PUBLIC SAFETY EMPLOYEES

The following persons are eligible to continue coverage under the ***Plan*** according to the provisions set out below:

1. Public safety ***employee,*** defined as a ***full-time*** firefighter, police officer, county police officer or sheriff who is in the employment of the ***employer*** as such, who is retired or receiving disability benefits under Indiana law provisions IC 36-8-6, IC 36-8-7, IC 36-8-7.5, IC 36-8-8 or IC 36-8-10.

2. The public safety ***employee's*** spouse.

3. The public safety ***employee's dependent*** when the ***dependent*** is less than nineteen (19) years of age (twenty-four (24) years of age if a ***full-time student***) or who is more than eighteen (18) years of age and physically or mentally disabled.

The ***employee*** may elect to have a spouse and/or ***dependent*** covered under the ***Plan*** at the time the ***employee*** retires or becomes disabled. The ***employee*** must file a written request for the coverage within ninety (90) days after retirement begins or disability benefits begin. The person must pay an amount equal to the total of the ***employer's*** and the ***employee's*** contribution for the ***Plan*** coverage for an active public safety ***employee.***

A surviving spouse or ***dependent*** who is eligible for coverage under the ***Plan*** as discussed above may elect to continue coverage under the ***Plan*** after the death of the public safety ***employee*** by filing a written request for coverage with the ***employer*** within ninety (90) days after the death of the public safety ***employee.*** The contribution that the public safety ***employee*** would have been required to pay for coverage under this provision must be paid to continue coverage.

A retired or disabled public safety ***employee's*** eligibility for the ***Plan*** under this provision ends on the earliest of:

1. When the public safety ***employee*** becomes eligible for ***Medicare*** coverage as prescribed by 42 U.S.C. 1395, et.seq., or

2. When the ***employer*** terminates the ***Plan.***

A surviving spouse's eligibility for the ***Plan*** under this provision ends on the earlier of:

1. When the surviving spouse becomes eligible for ***Medicare*** as prescribed by 42 U.S.C. 1395, et. seq., or

2. When the ***employer*** terminates the ***Plan*** for active public safety ***employees,*** or

3. The date of the surviving spouse's remarriage, or

4. When health insurance becomes available to the surviving spouse through employment.

A ***dependent's*** eligibility for the ***Plan*** under this provision ends on the earlier of:

1. When the ***dependent*** becomes eligible for ***Medicare*** coverage as prescribed by 42 U.S.C. 1395, et. seq., or

2. When the ***employer*** terminates the ***Plan*** for active public safety ***employees,*** or

3. When the ***dependent*** is no longer eligible for coverage due to age or disability status, or

4. When health insurance becomes available to the ***dependent*** through employment.

A public safety ***employee*** who is on leave without pay is entitled to coverage under this ***Plan*** for ninety (90) days if the ***employee*** pays an amount equal to the total of the ***employer's*** and ***employee's*** contribution for the coverage.

This provision covers public safety ***employees*** who retire, die or become disabled after June 30, 1989.

CERTIFICATES OF COVERAGE

The ***Plan administrator*** shall provide each terminating ***covered person*** with a Certificate of Coverage, certifying the period of time the individual was covered under this ***Plan.*** For ***employees*** with ***dependent*** coverage, the certificate provided may include information on all covered ***dependents.*** This ***Plan*** will at all times comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, dental and prescription drug benefits as provided under the ***Plan.***

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan,*** even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage:*

1. Death of the ***employee.***

2. The ***employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan.***

3. Divorce or legal separation from the ***employee.***

4. The ***employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan.***

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan.***

6. The last day of leave under the Family Medical Leave Act of 1993.

7. The call-up of an ***employee*** reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***employee,*** or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must notify the Human Resources Department of the ***employer,*** in writing, of that event within **sixty (60)** days of the event**.** The ***employee*** or ***dependent*** must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. **Failure to provide such notice to the *employer* will result in the person forfeiting their rights to continuation of coverage under this provision.**

2. Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the ***employee*** or ***dependent*** will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the ***Plan*** prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continued coverage, he must advise the ***employer*** in writing of this choice. The ***employer*** must receive this written notice no later than the last day of the sixty (60) day period. If the election

is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

a. The date coverage under the ***Plan*** would otherwise end; or
b. The date the person receives the notice from the ***employer*** of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the ***employer*** that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The ***employee*** or ***dependent*** must make payments for the continued coverage.

COST OF COVERAGE

1. The ***employer*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the ***employer*** or the ***employer's*** designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

2. For purposes of determining monthly costs for continued coverage, a person originally covered as an ***employee*** or as a spouse will pay the rate applicable to an ***employee*** if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an ***employee.***

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan.***

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent.*** The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an ***employee.***

2. Divorce or legal separation from an ***employee.***

3. ***Employee's*** entitlement to ***Medicare.***

4. The child's loss of ***dependent*** status.

If one of these subsequent qualifying events occurs, a ***dependent*** may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other ***dependent*** acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the ***employee.***

2. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***employee,*** divorce or legal separation from the ***employee,*** or the child's loss of ***dependent*** status.

3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment on the date specified by the ***employer.***

4. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan.

5. The date the ***covered person*** first becomes entitled to ***Medicare*** after the qualifying event.

6. The date the ***covered person*** first becomes covered under any other group health plan after the qualifying event, with exception of the ***pre-existing*** provision below.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the ***plan administrator*** (or its designee) is able to determine from such notice the ***employee*** and ***dependent(s)*** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this ***Plan,*** any notice required to be provided by any individual who is either the ***employee*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee*** or the ***dependent,*** and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    (a) A single notice addressed to both the ***employee*** or the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan,*** the spouse resides at the same location as the ***employee;*** and

    (b) A single notice to the ***employee*** or the spouse will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan,*** the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

In the event that a ***covered person*** becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an exclusion or ***pre-existing*** limitation on a condition that is covered by this ***Plan,*** the ***covered person*** may remain covered under this ***Plan*** with continuation of coverage and elect coverage under the other employer's group health plan. This ***Plan*** shall be primary payor for the ***covered expenses*** that are excluded or limited under the other employer sponsored group health plan and secondary payor for all other expenses.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is ***totally disabled*** may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the ***employer*** within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The ***employer*** may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage.

MILITARY MOBILIZATION

If an ***employee*** or an ***employee's dependent*** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the ***employee*** or the ***employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** or ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the ***employer*** may require the ***employee*** or ***employee's dependent*** to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The ***employee*** or the ***employee's dependent*** coverage will be reinstated without exclusions or a waiting period.

CLAIM FILING PROCEDURE

A claim for benefits is any request for a benefit which is provided by this ***Plan*** made by a ***covered person*** or the ***authorized representative*** of a ***covered person*** which complies with the ***Plan's*** procedures for making claims. Claims for health care benefits are one of two types: ***pre-service claims*** or ***post-service*** claims.

Pre-service claims are claims for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review.* A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person,*** provider or ***authorized representative*** to the ***Utilization Review Organization,*** as specified in *Utilization Review.*

Post-service claims are those for which services have already been received (any claims other than ***pre-service claims*****).**

If the ***covered person*** would like the ***Plan administrator/claims processor*** to deal with someone other than them regarding a claim for benefits then the ***covered person*** must provide the ***Plan administrator*** with a written authorization in order for an ***authorized representative*** (other than the ***employee***) to represent and act on behalf of the ***covered person.*** The ***covered person*** must consent to release information related to the claim to the ***authorized representative.***

FILING A PRE-SERVICE CLAIM

A ***pre-service claim*** begins when the ***covered person,*** provider, or the ***covered person's authorized representative*** makes a call to the ***Utilization Review Organization*** to precertify specified services, supplies or treatment. See *Utilization Review* for specific details regarding the services which require precertification, the number to call, and time frames for making the precertification call.

If a call is made to the ***Utilization Review Organization*** that fails to follow the precertification procedure as specified in *Utilization Review*, but at least identifies the name of the patient, a specific medical condition or symptom and the specific treatment, service or product for which precertification is being requested, the ***covered person*** or the ***covered person's authorized representative*** will be orally notified (in writing, if requested) within five (5) calendar days (twenty-four (24) hours in the case of Urgent Care Claims) of the failure to follow correct procedures.

Pre-service claims fall into three categories: Precertification Claims, Urgent Care Claims or Concurrent Care Claims.

A. A Precertification Claim is a claim for any services for which the ***Plan*** requires precertification, however the services which are required are not services which would qualify as Urgent Care Claims, as defined below.

B. Urgent Care Claims are claims for services which require precertification, however, the services are of such a nature such that the application of the longer time periods for making Precertification Claim determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or – in the opinion of a ***physician*** with knowledge of the patient's medical condition – would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

C. Concurrent Care Claims are claims for continuing care for which additional services are being requested or claims for which benefits for additional care are being reduced or terminated.

TIME FRAME FOR BENEFIT DETERMINATION OF A PRE-SERVICE CLAIM

When a ***pre-service claim*** has been submitted to the ***Plan*** (call made to the ***Utilization Review Organization***) and no additional information is required, the ***Plan*** will generally complete its determination of the claim within the following timeframes:

1. Precertification Claims – within a reasonable time frame, but no later than fifteen (15) calendar days from receipt of claim;

2. Urgent Care Claims – within a reasonable time frame, but no later than seventy-two (72) hours following receipt of claim;

3. Concurrent Care Claims – if a request for an extension of an on-going course of treatment is received, determination will be made as follows:

    a. If the request for additional care is of an urgent care nature and the request is made at least twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within twenty-four (24) hours of the request. If the request is made less than twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within seventy-two (72) hours of the request;

    b. For non-urgent care, the determination must be made within fifteen (15) calendar days after the request is received.

When a ***pre-service claim*** has been submitted to the ***Plan*** and additional information is needed in order to determine whether and to what extent, services are covered or benefits are payable by the ***Plan,*** then the ***Plan administrator*** or its designee (***Utilization Review Organization***), shall notify the ***covered person*** as follows:

1. If the ***pre-service*** claim is for care of an urgent care nature, the ***Plan administrator*** or its designee shall notify the ***covered person*** as soon as possible, but no later than twenty-four (24) hours after the initial call, of the specific information necessary to complete the claim. The ***covered person*** or ***authorized representative*** will have forty-eight (48) hours to provide the requested information and the ***Plan administrator*** or its designee will complete the claim determination no later than forty-eight (48) hours after receipt of the requested information. Failure of the ***covered person*** to respond in a timely and complete manner will result in a denial of the precertification request.

2. If the ***pre-service claim*** is for non-urgent care or if an extension of time is required due to reasons beyond the control of the ***Plan administrator*** or its designee***,*** the ***Plan administrator*** or its ***designee*** will, within fifteen (15) calendar days from the date of the initial call, provide the ***covered person*** or the ***covered person's authorized representative*** with a notice detailing the circumstances and the date by which the ***Plan administrator,*** or its designee, expects to render a decision. If additional information is required, the notice will provide details of what information is needed and the ***covered person*** will have forty-five (45) days to provide the requested information. The ***Plan administrator,*** or its designee, will complete its determination of the claim no later than fifteen (15) calendar days following receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of the precertification request.

NOTICE OF PRE-SERVICE CLAIM BENEFIT DENIAL

If the ***pre-service claim*** for benefits is denied, the ***Plan administrator*** or its designee shall provide the ***covered person*** or authorized representative with a written notice of benefit denial within the timeframes listed above.

The notice will contain the following:

A. Explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the ***Plan*** provisions on which the denial is based;
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary;
4. A description of the ***Plan's*** review procedure and applicable time limits;
5. A statement that if the ***covered person's*** appeal (See "Appealing a Denied Claim" below) is denied, the ***covered person*** has the right to bring a civil action.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request

APPEALING A DENIED PRE-SERVICE CLAIM

The Named Fiduciary for purposes of an appeal of a ***pre-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 is the ***Utilization Review Organization***.

A ***covered person,*** or the ***covered person's authorized representative***, may request a review of a denied claim by making written (for any claim involving urgent care, the request may be verbal) request to the Named Fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial. The written request should state the reasons the ***covered person*** feels the claim should not have been denied. The following describes the review process:

1. The ***covered person*** has a right to submit documents, information and comments

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information.

a. Relied on in making the benefit determination; or
b. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
c. That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions; or
d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review shall take into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be

   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim

6. If the original denial was, in whole or in part, based on medical judgment:

   a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provider*** utilized by the Named Fiduciary will be neither
      (1) An individual who was considered in connection with the original denial of the claim, nor
      (2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
   c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR PRE-SERVICE CLAIMS ON APPEAL

The Named Fiduciary shall provide the ***covered person*** or authorized representative with a written notice of the appeal decision within the following timeframes:

1. Urgent Care Claims or Concurrent Care Claims involving urgent care – as soon as possible, but not later than seventy-two (72) hours from receipt of appeal;

2. Precertification Claims or Concurrent Care Claims involving non-urgent care – as soon as possible, but not later than fifteen (15) calendar days from receipt of appeal;

If the appeal is denied, the notice will contain the following:

A. Explanation of the denial including:

   1. The specific reasons for the denial
   2. Reference to specific ***Plan*** provisions on which the denial is based
   3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
   4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:

   1. A copy of that criterion, or
   2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the Notice will supply either:

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request

FILING A POST-SERVICE CLAIM

1. A claim form is to be completed on each covered family member at the beginning of the calendar year and for each claim involving an ***injury***. Appropriate claim forms are available from the Human Resources Department. An annual Healthcare Information Form may be substituted for the claim form requirement per person.

   Claims should be submitted to:

   Stewart C. Miller & Co., Inc.
   PO Box 5769
   Lafayette, Indiana 47903-5769

2. All bills submitted for benefits must contain the following:

   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***employee.***
   d. Address of ***employee.***
   e. Name of ***employer.***
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Social Security number.
   h. Date of service.
   i. Diagnosis.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident***, injury*** or ***illness*** being treated.

3. Properly completed claims not submitted within fifteen (15) months after the date on which the liability was ***incurred*** will be denied.

The ***covered person*** may ask the provider to submit the bill directly to the ***claims processor,*** or the ***covered person*** may file the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim has been filed for benefits.

TIME FRAME FOR BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

When a completed claim has been submitted to the ***claims processor*** and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar day of receipt of the completed claim, unless an extension of time is necessary due to circumstances beyond the ***Plan's*** control.

When a completed claim has been submitted to the ***claims processor*** and additional information is required for determination of the claim, the ***claims processor*** will provide the ***covered person*** or ***authorized representative*** with a notice detailing the information needed. This notice will be provided within thirty (30) calendar days of receipt of the completed claim and will indicate the date when the ***claims processor*** expects to make a decision, if the requested information is received. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***claims processor*** will complete its determination of the claim within fifteen (15) calendar days of receipt of the requested information***.*** Failure to respond in a timely and complete manner will result in a denial of benefit payment.

NOTICE OF POST-SERVICE CLAIM BENEFIT DENIAL

If the ***post-service*** claim for benefits is denied, the ***Plan administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of benefit denial within thirty (30) calendar days of receipt of a completed claim, or if the ***Plan*** had requested additional information from the ***covered person*** or ***authorized representative***, within fifteen (15) calendar days of receipt of such information. The notice will contain the following:

A. Explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the ***Plan*** provisions on which the denial is based
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary
4. A description of the ***Plan's*** review procedure and applicable time limits
5. A statement that if the ***employee's*** appeal (See "Appealing a Denied Claim" below) is denied, the ***employee*** has the right to bring a civil action.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request

APPEALING A DENIED POST-SERVICE CLAIM

The "Named Fiduciary" for purposes of an appeal of a ***post-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) is the ***claims processor***.

A ***covered person,*** or the ***covered person's authorized representative***, may request a review of a denied claim by making written request to the "Named Fiduciary" within one hundred eighty (180) calendar days from receipt of notification of the denial. The request for review should state the reasons the ***covered person*** feels the claim should not have been denied.

The review process is as follows:

1. The ***covered person*** has a right to submit documents, information and comments

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information:

    a. Relied on in making the benefit determination, OR
    b. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon, OR
    c. That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions, OR
    d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be

    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim

6. If original denial was, in whole or in part, based on medical judgment,

    a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
    b. The ***professional provider*** utilized by the Named Fiduciary will be neither
        (1) An individual who was considered in connection with the original denial of the claim, nor
        (2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
    c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR POST-SERVICE CLAIM APPEAL

The ***Plan administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal. If the appeal is denied, the notice will contain the following:

A. An explanation of the denial including:

    1. The specific reasons for the denial
    2. Reference to specific ***Plan*** provisions on which the denial is based

3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the patient's medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following to the ***claims processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into dollars.

3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit.***

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this ***Plan,*** part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan.***

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage under a government program and any coverage required or provided by any statute;

5. Group automobile insurance;

6. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

7. Any plan or policies funded in whole or in part by an ***employer,*** or deductions made by an ***employer*** from a person's compensation or retirement benefits;

8. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan"*** shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan.***

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan.***

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant as a member(or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent.***

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) ***employee,*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***employee,*** or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage
   If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitation for ***pre-existing conditions*** or exclusions, the Other Plan shall be primary for all ***covered expenses*** which are not related to the ***pre-existing condition*** or exclusions. This ***Plan*** shall be primary for the ***pre-existing condition*** only.

7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any ***covered person.*** Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

SUBROGATION

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***Plan administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage

(whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***Plan administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***Plan administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

The ***Plan administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights; however, the ***Plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

THIS PLAN AND MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for ***Medicare*** Part A at no cost. Participation in ***Medicare*** Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage and is still actively at work**,** the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage and the ***employee*** is still actively at work**,** the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** is also enrolled in ***Medicare,*** this ***Plan*** shall pay as the primary plan. ***Medicare*** will pay as secondary plan.

4. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan. Medicare*** will be the only payor.

5. For a ***retiree, Medicare*** shall be the primary payor and this ***Plan*** shall be secondary.

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer.*** The ***employer*** is the ***Plan administrator.*** The ***Plan administrator*** shall have full charge of the operation and management of the ***Plan.*** The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the named fiduciary of the ***Plan*** for all purposes except claim appeals, as specified in *Claim Filing Procedure.* As fiduciary, the ***employer*** maintains discretionary authority with respect to those responsibilities for which it has been designated named fiduciary, including, but not limited to, interpretation of the terms of the ***Plan,*** and determining eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan;*** any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Benefits under this ***Plan*** will be paid only if the ***Plan administrator*** decides in his discretion that the applicant is entitled to them.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate,*** after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider.***

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan.*** Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the ***employer*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was January 1, 2001. The ***effective date*** of the modifications contained herein is February 1, 2005.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider.*** However, benefits will be paid in accordance with the provisions of this ***Plan,*** and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***nonpreferred provider.***

INCAPACITY

If, in the opinion of the ***employer,*** a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***employer*** may on behalf of the ***Plan,*** at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***employer*** or by the ***employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***employer*** or by the ***covered person,*** as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan.*** No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred,*** or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***employer*** shall not be liable for the negligence, wrongful act, or omission of any ***physician, professional provider, hospital,*** or other institution, or their employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***Plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure.*

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan.***

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan,*** or otherwise misleads the ***Plan,*** the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person,*** or from any other person responsible for misleading the ***Plan,*** and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under this ***Plan*** null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan,*** at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee.*** Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.*** Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***employer.***

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the ***Plan,*** should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***employee,*** COBRA to Active) and no interruption in coverage has occurred, the ***Plan*** will provide continuance of coverage with respect to any ***pre-existing condition*** limitation, deductible(s), ***coinsurance*** and ***maximum benefit.***

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***Plan administrator.***

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc. or by the ***Plan,*** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility;***

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a ***physician.***

Authorized Representative

An individual who the ***covered person*** has authorized (in writing) to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a provider to act as an ***authorized representative*** of a ***covered person.***

Birthing Center

A ***facility*** that meets professionally recognized standards and all of the following tests:

1. It mainly provides an ***outpatient*** setting for childbirth following a normal, uncomplicated ***pregnancy,*** in a home-like atmosphere.

2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.

3. It has a medical staff that: (a) is supervised full-time by a ***physician;*** and (b) includes a registered nurse at all times when ***covered persons*** are at the facility.

4. If it is not part of a ***hospital,*** it has written agreement(s) with a local ***hospital(s)*** and a local ambulance company for the immediate transfer of ***covered persons*** who develop complications or who require either pre or post-natal care.

5. It admits only ***covered persons*** who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.

6. It schedules ***confinements*** of not more than twenty-four (24) hours for a birth.

7. It maintains medical records for each ***covered person.***

8. It complies with all licensing and other legal requirements that apply.

9. It is not the office or clinic of one or more ***physicians*** or a specialized ***facility*** other than a ***birthing center.***

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

The company contracted by the ***employer*** which is responsible for the processing of claims for benefits under the terms of the ***Plan*** and other ministerial services deemed necessary for the operation of the ***Plan*** as delegated by the ***employer.***

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan.*** The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy,*** but is adversely affected by or caused by ***pregnancy.*** Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).

2. Ectopic ***pregnancy.***

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy.***

Concurrent Review

A review by the ***Utilization Review Organization*** which occurs during the ***covered person's hospital confinement*** to determine if continued ***inpatient*** care is ***medically necessary.***

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility*** or ***hospice*** due to an ***illness*** or ***injury*** diagnosed by a ***physician.*** Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician, professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury.*** ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury.*** Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

Dentist

A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a ***close relative*** of the ***covered person.***

Dependents

For a complete definition of ***dependent,*** refer to *Eligibility, Dependent Eligibility.*

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury;***

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment. Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency

The sudden onset of an ***illness*** or ***injury*** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the ***covered person's*** life in jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

Employee

A person directly involved in the regular business of and compensated for services by the ***employer,*** who is regularly scheduled to work not less than thirty-six (36) hours per work week on a ***full-time*** status basis and an individual who is an appointed or elected officials**.**

Employer

The ***employer*** is the City of Crown Point.

Experimental/Investigational

Services, supplies, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor,*** Named Fiduciary, ***Plan administrator*** or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The ***claims processor,*** Named Fiduciary, ***Plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor,*** Named Fiduciary, ***Plan administrator*** or their designee will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, or the ***covered person*** informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury,*** professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person.***

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders.***

6. It is approved and licensed by ***Medicare.***

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis ***facility,*** a lithotriptor center or an outpatient imaging center.

Full-time

Employee's regularly scheduled work not less than thirty-six (36) hours per work week.

Full-time Student or Full-time Student Status

An ***employee's dependent*** child who is enrolled in and regularly attending secondary school, an accredited college, university, or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain ***full-time student status.***

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Home Health Aide Services

Those services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person.***

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare.***

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician.***

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person.***

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals.***

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare.***

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury.***

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency,*** will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person.***

Incurred or Incurred Date

With respect to a ***covered expense,*** the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound***.***

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital, hospice,*** or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board.***

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician.***

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care.*** It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital;***

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a special enrollment period.

Layoff

A period of time during which the ***employee,*** at the ***employer's*** request, does not work for the ***employer,*** but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time,*** active work. Layoffs will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of stated duration after which time the ***employee*** is expected to return to active work***.***

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan.***

2. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense.*** The maximum amount can be for:

    a. The entire time the ***covered person*** is covered under this ***Plan,*** or
    b. A specified period of time, such as a calendar year.

3. The maximum number the ***Plan*** acknowledges as a ***covered expense.*** The maximum number relates to the number of:

    a. Treatments during a specified period of time, or
    b. Days of ***confinement,*** or
    c. Visits by a ***home health care agency.***

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the ***claims processor,*** Named Fiduciary, ***employer/Plan administrator*** or their designee, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered;

2. Supplied or performed in accordance with current standards of good medical practice within the United States***;*** and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider;*** and

4. Is an appropriate supply or level of service that safely can be provided; and

5. It is recommended or approved by the attending ***professional provider.***

The fact that a ***professional provider*** may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment ***medically necessary.*** In making the determination of whether a service or supply was ***medically necessary,*** the ***claims processor, employer/Plan administrator***, or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***claims processor, employer/Plan administrator*** or its designee shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C,

Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Morbid Obesity

A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or twice the medically recommended weight in the most recent Metropolitan Life Insurance company tables for a person of the same height, age and mobility as the ***covered person.***

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan.***

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy.***

Nonpreferred Provider

A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient;***

2. A ***physician's*** office, laboratory or x-ray ***facility;*** or

3. An ***ambulatory surgical facility;*** and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.

2. Treatment of ***mental and nervous disorders.***

3. ***Chemical dependency*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted within the ***Pharmacy Organization***.

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is practicing within the scope of his license.

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***Plan administrator*** is responsible for the day-to-day functions and management of the ***Plan.*** The ***Plan administrator*** is the ***employer.***

Post-service Claim

Post-service claims are those for which services have already been received (any claims other than ***pre-service claims***).

Pre-existing Conditions

An ***illness*** or ***injury*** which existed within three (3) months before the ***covered person's*** enrollment date for coverage under this ***Plan.*** An ***illness*** or ***injury*** is considered to have existed when the ***covered person:***

1. Sought or received professional advice for that ***illness*** or ***injury,*** or

2. Received medical care or treatment for that ***illness*** or ***injury,*** or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury.***

Preferred Provider

A ***physician, hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals, physicians,*** and other health care providers to provide ***covered persons*** services, supplies and treatment at a ***negotiated rate.*** The ***Preferred Provider Organization*** is Sagamore Health Network.

Pregnancy

The physical state which results in childbirth or miscarriage.

Pre-service Claim

A ***pre-service claim*** is a claim for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review.* A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person,*** provider or ***authorized representative*** to the ***Utilization Review Organization,*** as specified in *Utilization Review.*

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** are:

Certified Addictions Counselor

Certified Registered Nurse Anesthetist

Certified Registered Nurse Practitioner

Chiropractor

Clinical Laboratory

Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)

Dental Hygienist

Dentist

Dietician

Midwife

Nurse (R.N., L.P.N., L.V.N.)

Occupational Therapist

Physical Therapist

Physician

Physician's Assistant

Podiatrist

Psychologist

Respiratory Therapist

Speech Therapist

Retiree

A former ***employee*** who retired from service of the ***employer*** and has met the ***Plan's*** eligibility requirements to continue coverage under the ***Plan*** as a ***retiree.*** Unless otherwise specified, as used in this document, the term ***employee*** shall include ***retirees*** covered under the ***Plan.***

Retrospective Review

A review by the ***Utilization Review Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was ***medically necessary.***

Room and Board

Room and linen service, dietary service, including meals, ***medically necessary*** special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in it's ***semiprivate*** rooms containing two (2) or more beds.

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital,*** but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency*** or ***mental and nervous disorders,*** and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the ***physician.***

c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person.***

d. It provides at least the following basic services:
   (1) ***Room and board***
   (2) Evaluation and diagnosis
   (3) Counseling
   (4) Referral and orientation to specialized community resources.

Utilization Review

A process of evaluating if services, supplies or treatment are ***medically necessary*** to help ensure cost-effective care.

Utilization Review Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary.*** The ***Utilization Review Organization*** is Individualized Case Management (ICM)